

**Memorandum of Understanding (MOU)**

*Between*

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

*And*

**The Michigan Department of Community Health**

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

**Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid**

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## **I. STATEMENT OF INITIATIVE**

The Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Community Health (MDCH), Medical Services Administration will partner to implement the Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “dual eligibles”). The Demonstration will include a three-way contract with Integrated Care Organizations (ICOs) that will provide integrated benefits to Medicare-Medicaid enrollees in the targeted geographic area(s). The Demonstration will begin no earlier than January 1, 2015 and continue through December 31, 2017, unless terminated pursuant to section III.L or continued pursuant to section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and life, and reduce costs for both MDCH and the federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

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 III.C.1 below provides more information on individuals who are not eligible for the program as well as individuals who are eligible if they disenroll from an existing program.

Under this initiative, ICOs will be required to provide for—either directly or, through subcontracts, or through partnership with local Prepaid Inpatient Health Plans (PIHP)—all Medicare and Medicaid-covered services, as well as additional items and services, under a capitated model of financing. CMS, MDCH, and the ICOs will ensure that enrollees have access to an adequate network of medical and supportive services.

CMS and MDCH shall jointly select and monitor the ICOs. CMS will implement this initiative under demonstration authority for Medicare and demonstration, 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:

- Provide seamless access to supports and services for Medicare-Medicaid enrollees
- Create a person-centered model to coordinate supports and services that communicates with and links back to all domains of the delivery system
- Streamline administrative processes for Medicare-Medicaid enrollees and providers
- Eliminate barriers to and encourage the use of home and community based services
- Provide quality services that also focus on enrollee satisfaction

- Demonstrate cost effectiveness for the state and federal governments through improved supports and care coordination, financial realignment, promotion of best practices, and payment reforms.

Team-based care is the provision of health and related support services to individuals, families, by at least two providers who work collaboratively with individuals and their caregivers to accomplish shared goals within and across settings to achieve coordinated, high-quality care. Recent collaborative efforts between MDCH's Medicaid Health Plans PIHPs to improve physical health care outcomes for people served by these two entities have provided examples and lessons related to the importance of shared communication and coordination in team-based care. From this experience, MDCH has gained insight into necessary quality strategies and measures that can be used to encourage coordination across team members.

CMS and MDCH expect this model of integrated care and financing to, among other things, improve quality of care, reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting enrollees' needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and MDCH expect to achieve these goals through ICO and provider implementation of the independent living and recovery philosophy, wellness principles, cultural competence, and promotion of culture change.

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, ICOs 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 ICOs, MDCH, and CMS.

As part of this initiative, CMS and MDCH will test a new Medicare and Medicaid payment methodology designed to support ICOs 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 MDCH will allow ICOs 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 enrollee safeguards and will be included in this MOU and the three-way contract. ICOs will have full

accountability for managing the capitated payment to best meet the needs of enrollees according to Individual Integrated Care and Supports Plans developed by enrollees, their caregivers, and Integrated Care Teams using a person-centered planning process. CMS and MDCH expect ICOs to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, ICOs will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the enrollees' wishes, needs, and Individual Integrated Care and Supports Plan.

Preceding the signing of this MOU, MDCH 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 Michigan plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and MDCH plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with ICOs setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about ICO 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, MDCH and CMS will ultimately enter into three-way contracts with selected plans, which will have also met the Medicare components of the Plan selection process, including submission of a successful Capitated Financial Alignment Application, and adherence to any annual contract renewal requirements and guidance updates, 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 the parties intend to incorporate into the three-way contracts, as well as those activities the parties intend to conduct prior to entering into the three-way contracts and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

- 1. Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and 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, ICOs will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 C.F.R. § 422 and § 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the three-way contract.
- 2. Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the 1915(b) and 1915(c) waivers for those ICO enrollees in a 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, ICOs will be required to comply with Medicaid managed care requirements under Title XIX and 42 C.F.R. § 438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the three-way contract.

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

- 1. ICO Procurement Document:** The State issued a request for proposals (RFP) that, consistent with applicable State law and regulations, included purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 14, 2014 guidance from CMS, ICOs are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process.

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

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

public interest or promote the objectives of Title XVIII. CMS will promptly notify MDCH 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 MDCH 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, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

- 4. Medicaid Waiver and/or Medicaid State Plan Approval:** CMS approval of any new Medicaid waivers pursuant to Sections 1115, 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 MDCH 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 MDCH an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase-out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.
- 5. Readiness Review:** CMS and MDCH, either directly or with contractor support, shall conduct a readiness review of each selected ICO. Following the signing of the three-way contract, CMS and MDCH must agree that an ICO has passed readiness prior to that Plan accepting any enrollment. CMS and MDCH 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 ICO and its ability to meet all program requirements, including having an adequate network that addresses the full range of enrollee needs, and the capacity to uphold all enrollee safeguards and protections.
- 6. Three-way Contract:** CMS and MDCH 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;
- Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly patient pay amount.); and
- Reside in a Demonstration region.

The following populations will be excluded from enrollment in the Demonstration:

- Individuals under the age of 21
- Individuals previously disenrolled due to Special Disenrollment<sup>1</sup> from Medicaid managed care
- Individuals not living in a Demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend downs or deductibles)
- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services

To avoid duplication of services, individuals enrolled in the MI Choice waiver program (a 1915(c) waiver) and related Money Follows the Person (MFP) program, or the Program for All-inclusive Care for the Elderly (PACE) may choose to participate in the Integrated Care Program, but only if they elect to disenroll from MI Choice, MFP, or PACE. Services similar to those offered through the MI Choice waiver or PACE will be offered through the Demonstration. Medicare-Medicaid enrollees that are enrolled in Medicaid-only managed care are eligible and will be passively enrolled in the Demonstration.

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<sup>1</sup> The ICO may initiate special disenrollment requests for behaviors as defined in 42 CFR 438.56.

## **Populations Excluded from Passive Enrollment**

As described below, the Demonstration will include passive enrollment in certain instances into ICOs when individuals do not make an active choice about enrollment into the Demonstration. Individuals in the following categories will not be eligible for passive enrollment in the Demonstration, but may choose to participate through opt-in enrollment. Those electing to participate in the Demonstration must disenroll from the program from which they are currently receiving services.

- Individuals enrolled in MI Choice, MFP, or PACE
- Individuals enrolled in an employer sponsored Medicare Advantage health plan. Education will be emphasized for individuals in this population.

- 2. Enrollment and Disenrollment Processes:** The Demonstration will begin with an opt-in period during which the enrollment will only be among those individuals who choose to participate. Eligible individuals will be notified of their right to select among contracted ICOs no fewer than thirty (30) days prior to the first effective date of enrollment. For eligible individuals who do not participate in the opt-in period – either by choosing an ICO or expressing a preference not to participate in the Demonstration – enrollment into an ICO may be conducted using a seamless, passive enrollment process. Individuals eligible for passive enrollment will be notified no fewer than 60 days prior to the enrollment effective date of plan assignment, the opportunity to choose among ICOs, choose not to participate in the Demonstration, or choose to disenroll from an ICO at any time after enrollment. Prior to the effective date of their enrollment, beneficiaries who would be passively enrolled will have the opportunity to opt out until the last day of the month, and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7. Disenrollment from ICOs and enrollment from one ICO to a different ICO shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and MDCH 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 MDCH will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular ICO to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and MDCH may discontinue further passive enrollment into an ICO. Any illegal marketing practices will be referred to appropriate agencies for investigation. As mutually agreed upon, and as discussed further in Appendix 7 and the three-way contract, CMS and MDCH will utilize an independent third party entity to facilitate all enrollments into the ICOs. ICO

enrollments, including enrollments from one ICO to a different ICO, and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and federal financial participation will continue through the end of that month.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and MDCH shall develop uniform enrollment and disenrollment forms and other documents.
4. **Outreach and Education:** ICO outreach and marketing materials will be subject to a single set of marketing rules developed by CMS and MDCH, as further detailed in Appendix 7.
5. **Single Identification Card:** CMS and MDCH shall work with ICOs to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.
6. **Interaction with other Demonstrations:** To best ensure continuity of beneficiary care and provider relationships, CMS will work with MDCH 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, assigned, or have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

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

1. **ICO Service Capacity:** CMS and MDCH shall contract with ICOs 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 C.F.R. §422 and 42 C.F.R. §423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1915(b) and/or 1915(c) waivers, and in accordance with the requirements specified by the State's RFP and this MOU. In accordance with the three-way contract and this MOU, CMS and MDCH may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, MDCH, and ICOs will ensure that beneficiaries have access to an adequate network of medical, pharmacy, durable medical equipment, behavioral health, and long-term supports and services (LTSS) providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. **ICO Risk Arrangements:** CMS and MDCH shall require each ICO to provide a detailed description of its risk arrangements with providers under subcontract with the ICO. This description shall be made available to Plan enrollees upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical services to enrollees.
3. **ICO Financial Solvency Arrangements:** CMS and MDCH have established a standard for all ICOs, as articulated in Appendix 7.

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

1. **Choice of Plans:** Where multiple ICOs serve the same region, beneficiaries may choose the ICO that provides the higher quality service and best meets their individual needs within the constraint of regional availability.
2. **Choice of Providers:** Enrollees will have freedom of choice of providers within the ICO networks. ICOs will contract with a diverse group of specialists, hospitals, nursing facilities, and home and community based service providers including personal care aides, and other providers to ensure rights of choice.
3. **Self-Determination Arrangements:** ICOs will be required to offer enrollees' arrangements that support self-determination as an option within its LTSS benefit package. This service allows enrollees to choose their own LTSS providers within an established individualized budget managed by the enrollee with support from a fiscal intermediary.
4. **Continuity of Care:** CMS and MDCH will require ICOs to ensure that enrollees continue to have access to medically necessary items, services, and medical and long-term supports and service providers for the transition period as specified in Appendix 7. In addition, ICOs will advise enrollees and their providers of services that are provided during the transition period that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, ICOs must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Continuity of care may also require continuity of participation in the Demonstration, which in turn depends on uninterrupted eligibility for, and enrollment in, Medicaid, as appropriate. Therefore, ICOs also will be required to promote continuity of care by providing timely assistance to enrollees who need help with paperwork, verification, or other steps to maintain their eligibility for, and enrollment in, Medicaid at annual or interim redeterminations of eligibility.

- 5. Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, MDCH will provide persons eligible for participation in the Demonstration with enrollment assistance and options counseling independent from the ICO to help them make enrollment decisions that best meet the needs of individuals. MDCH will work with Michigan's Medicare Medicaid Assistance Program (MMAP) and its network, Michigan's Enrollment Broker, and other local partners to ensure ongoing outreach, education, and support to beneficiaries eligible for the Demonstration.
- 6. Ombudsman:** MDCH will establish an Integrated Care Ombudsman Program for this Demonstration independent and external to the ICOs. The purpose of this new program is to advocate on behalf of all enrolled individuals. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS, the Administration for Community Living (ACL), and MDCH will provide ongoing technical assistance to the Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight of ICOs, with a focus on compliance with principles of community integration, independent living, and person-centered supports and services in the home and community based care context. The Ombudsman must obtain, when necessary, the enrollee's authorization to access enrollee records. The Ombudsman must obtain, when necessary, the enrollee's permission to enter a setting where the enrollee lives or is receiving services. Enrollees must have unfettered access to the Ombudsman or other advocates of the enrollee's choice. The Ombudsman will be responsible for gathering and reporting data from Ombudsman activities to MDCH and CMS.
- 7. Person-Centered Planning:** ICOs shall ensure that a person-centered planning process is used to develop an Individual Integrated Care and Supports Plan (IICSP). Enrollees receiving supports and services have a right to choose an independent or external facilitator of the person-centered planning process. ICOs will ensure that medically necessary services are provided to enrollees in accordance with criteria established in the Medicaid policy, in the most integrated community setting, and in accordance with the enrollee's wishes and IICSP. Sufficient investment in training in the person-centered planning process will be made to assure competency in its application as the basis for all supports and services.
- 8. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and MDCH expect ICO and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the ICO model and to support better outcomes for ICO enrollees. In particular, CMS and MDCH recognize that successful person-centered supports and services require physical access to buildings, services and equipment and flexibility in scheduling and processes. MDCH and CMS will require ICOs to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling

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

- 9. Enrollee Communications:** CMS and MDCH agree that enrollee and prospective enrollee materials, in all forms, shall require prior approval by CMS and MDCH unless CMS and MDCH agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and MDCH. CMS and MDCH 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., Administrative Law Judge hearings), and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries who will be enrolled in the ICOs their caregivers and chosen or legal representatives. This includes individuals with disabilities, including, but not limited to, those with cognitive, sensory, and functional limitations, and those with limited English proficiency, in accordance with current federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

- 10. Enrollee Participation on Governing and Advisory Boards:** CMS and MDCH will require ICOs to obtain meaningful enrollee and community input on issues related to Demonstration management, quality, and enrollee services and supports. Each ICO must establish at least one advisory board and a process for that board to provide input to the governing board of the health maintenance organization (HMO). The ICO must also assure that the advisory board composition reflects the diversity of the Demonstration.

The advisory board should include a mix of enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations, with one third of the advisory board composed of enrollees.

MDCH will maintain additional processes for ongoing stakeholder participation and public comment.

The ICO must have written policies and procedures for advisory board elections detailing, at a minimum, the following:

- How the members of the advisory board will be elected
- The length of the term for advisory board members
- The process for filling vacancies
- Procedures for providing notice to enrollees

The advisory board members must meet at least quarterly and provide a permanent record of proceedings that are reported to MDCH. ICOs must accommodate and support the advisory board members by arranging necessary transportation, appropriate communications, and other measures to ensure and encourage their full participation on the advisory board.

A member of the HMO's governing board must participate on the advisory board and serve as the advisory board's direct liaison to the HMO governing body.

The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.

**11. ICO Customer Service Representatives:** CMS and MDCH shall require ICOs to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to enrollee complaints and concerns. The ICO shall assure that customer service representatives are also responsive and provide timely access to information to the enrollee's authorized representatives with appropriate written authorization from the enrollee. ICOs shall maintain simple, streamlined policies and procedures for customer service representatives to obtain, when necessary, the enrollee's written or verbal authorization to release information to the authorized representative verbally or electronically (e.g., text message, American Sign Language, Facetime, Skype, Google+), or by fax without delaying access to information or assistance.

In addition, CMS and MDCH shall themselves employ or contract with sufficient call center and customer service representatives to address enrollee questions and concerns. ICOs, CMS, and MDCH shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

- 12. Privacy and Security:** CMS and MDCH shall require all ICOs to ensure privacy and security of enrollee health records, and provide for access by enrollees to such records in accordance with HIPAA, other applicable federal and state laws and regulations, and the three-way contract.
- 13. Integrated Appeals and Grievances:** As referenced in section F and Appendix 7, Medicare-Medicaid beneficiaries will have access to an integrated appeals and grievance process.
- 14. Limited Cost Sharing:** ICOs will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including both those covered by both Medicare Part D and Michigan Medicaid), ICOs will not be permitted to charge co-pays to enrollees. ICOs will not assess any cost sharing for Michigan Medicaid services. Enrollees residing in nursing facilities will continue to be responsible for patient pay amounts (deductibles) determined by the Michigan Department of Human Services.
- 15. No Balance Billing:** No enrollee may be balance billed by any provider for any reasons for services covered under this Demonstration.

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

- 1. ICO Grievances and Internal Appeals Processes:** CMS and MDCH agree to utilize a unified set of requirements for ICO grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more enrollee-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All ICO Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and MDCH. 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 Michigan Medicaid. PIHPs will use integrated notices and forms specific to the Demonstration, but the grievance and appeals processes for PIHP related issues will remain the same. CMS and Michigan Medicaid will work to continue to coordinate grievances and appeals for all services.

2. **External Appeals Processes:** CMS and MDCH agree to utilize a streamlined Appeals process that will conform to both Medicare and Medicaid requirements, to create a more enrollee friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules.

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

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

These activities shall include but not be limited to:

- Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Health Outcomes Survey (HOS) data, enrollment and disenrollment reports.
  - Reviewing any other performance metrics applied for quality withhold or other purposes.
  - Reviewing reports of enrollee complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
  - Reviewing and analyzing reports on ICOs' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste and abuse as may be agreed upon by CMS and MDCH, and ensuring that ICOs take corrective action, as appropriate.
  - Reviewing and analyzing reports on ICOs' network adequacy, including the Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
  - Reviewing any other applicable ratings and measures.
  - Reviewing reports from the Ombudsman.
  - Reviewing direct stakeholder input on both plan-specific and systematic performance.
  - Responding to and investigating enrollee complaints and quality of care issues.
2. **Day-to-Day ICO Monitoring:** CMS and MDCH will establish procedures for ICO daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- The State and CMS will each retain, yet coordinate, current responsibilities toward the enrollees such that enrollees maintain access to their benefits across both programs.
  - CMS and MDCH will leverage existing protocols (for example, in responding to enrollee complaints, conducting account management, and analyzing enrollment data) to identify and solve enrollee access problems in real-time.
  - Oversight will be coordinated and subject to a unified set of requirements. CMS and MDCH will establish joint Contract Management Teams, as described in Appendix 7. Oversight will build on areas of expertise and capacity of MDCH and CMS.
  - Oversight of the ICOs and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and MDCH’s Medicaid 1915(c) waiver and managed care programs.
  - Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with MDCH. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.
  - CMS and MDCH will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the three-way contract.
- 3. Consolidated Reporting Requirements:** CMS and MDCH shall define and specify in the three-way contract a Consolidated Reporting Process for ICOs 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 ICO’s performance. ICOs will be required to meet the encounter reporting requirements that are established for the Demonstration. See Appendix 7 for more detail.
- 4. Accept and Process Data:** CMS, or its designated agent(s), and MDCH shall accept and process uniform person-level enrollee Data, for the purposes of program eligibility, payment,

and evaluation. Submission of data to MDCH and CMS must comply with all relevant federal and state laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and MDCH shall streamline data submissions for ICOs wherever practicable.

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

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

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

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

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

- 1. Evaluation Data to be Collected:** CMS and MDCH 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 ICOs, and/or their contractors collect and report to CMS and MDCH the data needed for evaluation.
- 2. Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. The evaluation will include changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, behavioral health, and long-term care and support services use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. MDCH will collaborate with CMS or its designated agent during all monitoring and evaluation activities. MDCH and ICOs will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the three-way contract with ICOs. MDCH and ICOs will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

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

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

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

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

- 1. Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources or from modifying the Medicare and Medicaid programs as allowed under the respective federal laws and regulations. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
- 2. Modification:** Either CMS or MDCH may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.
- 3. Termination:** The parties may terminate this MOU under the following circumstances:
  - a. Termination without cause - Except as otherwise permitted below, a termination by CMS or MDCH for any reason will require that CMS or MDCH provides a minimum of 90 days advance notice to the other entity, 90 day advance notice to the participating plan, and 60 days advance notice is given to enrollees and the general public.
  - b. Termination pursuant to Social Security Act §1115A(b)(3)(B).
  - c. Termination for cause - Either party may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU.
  - d. Termination due to a Change in Law - In addition, CMS or MDCH 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 MDCH with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration enrollees, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

- 4. Demonstration phase-out.** Termination at the end of the Demonstration must follow the following procedures:
- a. Notification – Unless CMS and MDCH agree to extend the Demonstration, MDCH must submit a draft phase-out plan to CMS no less than five (5) months before the effective date of the Demonstration’s suspension or termination. Prior to submitting the draft phase-out plan MDCH must publish on its website the draft phase-out plan for a 30-day public comment period. MDCH shall summarize comments received and share such summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.
  - b. Phase-out Plan Requirements - MDCH must include, at a minimum, in its phase-out plan the process by which it will notify affected enrollees, the content of said notices, including information on how enrollee appeal rights will continue to operate during the phase-out and any plan transition, and if applicable, the process by which MDCH will conduct administrative reviews of Medicaid eligibility for the affected enrollees, and ensure ongoing coverage for eligible enrollees, including plans for making an appropriate referral for enrollment of all enrollees in a Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing ICO and State responsibilities and close-out costs. If the Demonstration is terminated as set forth in Paragraphs 3a.- 3d. above, CMS shall provide MDCH with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration enrollees. During the phase-out period, all enrollees must be successfully enrolled in a Medicare Part D plan prior to termination of the Demonstration
  - c. Phase-out Procedures - MDCH must comply with all notice requirements found in 42 C.F.R. §431.206, §431.210 and §431.213. In addition, MDCH must assure all appeal and hearing rights afforded to Demonstration enrollees as outlined in 42 C.F.R. §431.220 and §431.221. If a Demonstration enrollee requests a hearing before the date of action, MDCH must maintain benefits as required in 42 C.F.R. §431.230. If applicable, MDCH must conduct administrative renewals for all affected enrollees in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
  - d. FFP - If the Demonstration is terminated by either party or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling individuals.

**M. SIGNATURES**

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

In Witness Whereof, CMS and MDCH have caused this Agreement to be executed by their respective authorized officers:

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

Marilyn Tavenner APR - 3 2014  
DATE

Marilyn Tavenner  
Administrator

Stephen Fitton 4/2/14  
DATE

Stephen Fitton  
Medicaid Director, Michigan Medical Services Administration

## **Appendix 1: Definitions**

**Action** – Includes 1) the denial or limited authorization of requested coverage , including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized services; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide services in a timely manner, as defined by MDCH; 5) the failure of an ICO or PIHP to act within the timeframes provided in §438.408(b); or 6) for a resident of a rural area with only one ICO, the denial of a Medicaid enrollee’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

**Appeals** – An enrollee’s request for review of an action taken by an Integrated Care Organization or a Prepaid Inpatient Health Plan regarding a coverage or payment determination.

**Behavioral Health Services and Supports** – An array of mental health and substance use outpatient and inpatient clinical interventions and monitoring, and community-based supports, aimed at helping individuals reduce symptoms of serious mental illness or substance use disorder, improve their ability to function in life and move toward recovery.

**Beneficiaries** – Individuals eligible for Medicare and Medicaid who meet the criteria indicated within this MOU.

**Care Bridge** – The care coordination framework for Michigan’s integrated care program. Through the Care Bridge, the members of an enrollee’s care and supports team facilitate formal and informal services and supports in an enrollee’s person-centered care plan. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the care and supports team.

**Care Coordination** – A process used by a person or team to assist enrollees in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.

**Care Coordination Platform** – An electronic platform supported by web-based technology that will manage communication and information flow regarding referrals, care transitions, and care delivery; facilitate timely and thorough coordination and communication among the enrollee, ICO, PIHP, the primary care provider, LTSS Supports Coordinators and other providers; provide prior authorization information for services; and house the Integrated Care Bridge Record.

**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.

**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 Michigan Medicaid representatives responsible for overseeing the contract.

**Covered Individuals** – Individuals enrolled in the Demonstration, including the duration of any month in which their eligibility for the Demonstration ends.

**Covered Services** – The set of required services offered by the ICOs.

**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.

**Enrollee** – See Covered Individuals.

**Enrollee Communications** – Materials designed to communicate to enrollee's plan benefits, policies, processes and/or enrollee rights.

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

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

**Grievance** – An expression of dissatisfaction about any matter other than an action as defined

above. The term is also used to refer to the overall system that includes grievances and appeals handled at the ICO or PIHP level and access to CMS and MDCH fair hearing process. 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.

**Health Insuring Corporation (HIC)** – A corporation licensed by the state that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

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

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

**ICO Care Coordinator** – A Michigan licensed registered nurse, nurse practitioner, physician's assistant, or Bachelor's or Master's prepared social worker employed or contracted with the ICO who is accountable for providing care coordination services. The ICO Care Coordinator will conduct at a minimum the Level I Assessment, assure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions and lead the ICT. Care Coordinators must coordinate these activities with the PIHP Supports Coordinator/Case Manager or LTSS Supports Coordinator and ICT members as appropriate.

**Individual Integrated Care and Supports Plan (IICSP)** – The plan of care developed by an enrollee, the enrollee's ICO Care Coordinator and the enrollee's Integrated Care Team which incorporates the following elements: assessment results; summary of the enrollee's health; the enrollee's preferences for care, supports and services; the enrollee's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring and reassessment; and the due date for the intervention and reassessment. The IICSP is also referred to as person-centered plan or plan of care. The IICSP

will be maintained in the Integrated Care Bridge Record.

**Integrated Care Bridge Record (ICBR)** – An individualized enrollee record generated and maintained within the electronic Care Coordination platform. It allows secure access for enrollees and the ICT to use and (where appropriate) update information.

**Integrated Care Organization (ICO)** – A HIC contracted to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees including long term services and supports.

**Integrated Care Team** – A team including the enrollee, enrollee’s chosen allies or legal representative, Primary Care Physician, ICO Care Coordinator, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed. The ICT works with the enrollee to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for each enrollee.

**Level I Assessment** – A broad assessment tool that will be used to assess the enrollee’s current health and functional needs within 45 calendar days of enrollment. This assessment will serve as the basis for further assessment needs that may include LTSS, BH and I/DD.

**Level II Assessment** – Based on the findings from the Level I Assessment, for enrollees identified with BH, I/DD, LTSS or complex medical needs, the ICO will collaborate with the regional PIHP or the regional LTSS providers to conduct the Level II Assessment based on the enrollee’s needs.

**Local Services** – those that are non-reimbursed or are provided through entities such as churches, senior centers, or community resources.

**Long Term Supports and Services (LTSS)** – A range of supports and services designed to meet an individual’s needs in the most integrated setting and to enable a person to live as independently as possible. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings.

**Low Income Newly Eligible Transition Program (LINet)** – program that provides temporary Part D prescription drug coverage for low income Medicare beneficiaries not already in a Medicare drug plan.

**MDCH** – Michigan Department of Community Health

**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 Michigan 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 Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person’s diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those services and supports designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.

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

**Medicare Medicaid Assistance Program (MMAP)** – MMAP is Michigan’s State Health Insurance Program (SHIP) that assists individuals in understanding the Medicare and Medicaid programs and provides enrollment assistance to persons seeking guidance on health care options.

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

**Medicare-Medicaid Enrollees** – For the purposes of this Demonstration, individuals who are enrolled in Medicare Parts A, B and D and Medicaid and no other comprehensive private or public health coverage.

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

**Medication Review and Reconciliation** –This includes the review of a medication regimen (including prescribed medication, over-the-counter medications, and herbal supplements) to ensure it is appropriate for the individual, determine appropriate use, identify potential medication interactions, protect the individual against over-medication, and possibly educate and

train family members or caretakers.

**MI Choice** – Michigan’s existing Medicaid 1915 (c) home and community based services waiver for individuals who are elderly or physically disabled. Individuals enrolled in MI Choice must opt-out of their existing program to participate in the demonstration.

**Michigan Compiled Laws (MCL)** – Contains all Michigan statutes of a general and permanent nature passed by the Michigan Legislature and signed by the governor.

**Michigan Department of Insurance and Financial Services (DIFS)** – The agency responsible for regulation of all insurers operating in the state of Michigan.

**Michigan Medicaid** – The Medical Services Administration (MSA) is the agency responsible for administering the Medicaid program in the state of Michigan.

**Nursing Facility Services** – Long-term or rehabilitation services provided in a licensed and certified nursing facility designed to meet an individual's needs.

**Opt In** – A process by which a beneficiary can choose to participate in the Demonstration.

**Opt Out** – A process by which a beneficiary can choose to not participate in the Demonstration and instead receive his or her Medicare and Medicaid benefits through other available options.

**Passive Enrollment** – An enrollment process through which an eligible individual is enrolled by the State (or its vendor) into an ICO, when not otherwise affirmatively electing one, following a minimum 60-day notice that includes the plan selection and the opportunity to select a different ICO, decline enrollment into an ICO, or opt out of the Demonstration prior to the effective date.

**Person-Centered Planning Process** – A process for planning and supporting a person receiving services that builds on the individual’s desire to engage in activities that promote community life and that honor the person’s preferences, choices, and abilities. The person-centered planning process is led by the person and involves families, friends, legal representative, and professionals as he/she desires or requires.

**Pre-paid Inpatient Health Plan (PIHP)** – PIHPs manage the Medicaid specialty services under the 1915(b)(c) Waiver Program, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance use services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and supports, or substance use services.

**Privacy** – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 C.F.R. 431.300 through 431.307, as well as relevant Michigan 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 agreement with MDCH and CMS, each ICO selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each ICO's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and MDCH will use the results to inform their decision of whether the ICO 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 ICO's headquarters.

**Reassessment** – A detailed assessment of the enrollee at specified intervals and/or after a change in health status.

**Self-Determination** – Provision of the opportunity for an enrollee to exercise choice and control in identifying, accessing, and managing services and supports in accordance with his or her needs and personal preferences. Arrangements that support self-determination means that the enrollee has the authority to exercise decision making over long-term care services and supports and accepts the responsibility for taking a direct role in managing them. Arrangements that support self-determination are an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the service plan developed through the person-centered planning process. Self-determination promotes personal choice and control over the delivery of long term care services and supports, including who provides services, how they are delivered, and hiring and firing personal attendants and/or home care workers,.

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

**State** – The State of Michigan.

**Supports Coordinator** – The supports coordinator (the LTSS Supports Coordinator and/or

PIHP Supports Coordinator) is a member of the Integrated Care Team who is available to enrollees who have identified LTSS, behavioral health, intellectual/developmental disabilities, or substance use needs. The supports coordinator collaborates with the enrollee and the ICO Care Coordinator to assure all necessary services and supports are provided to enable the enrollee to achieve desired outcomes. Refer to Appendix 7 section IV, for additional details specific to the LTSS Supports Coordinator and PIHP Supports Coordinator.

**Three-way Contract** – The three-way agreement that CMS and Michigan enters into with an ICO specifying the terms and conditions pursuant to which a participating ICO may participate in this Demonstration.

**Treating Providers** – A treating provider is someone who provides or has provided clinical treatment or evaluation and who has, or has had, an ongoing treatment relationship within the past 12 months. Generally, an ongoing treatment relationship is considered to be when the clinical evidence establishes that the enrollee sees, or has seen, the provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation and/or service required for clinical need(s). Treating providers include primary care physicians, specialists, physician assistants, nurse practitioners, psychiatrists, counselors, and therapists. Treating providers are not those who provide services that are non-clinical in nature or provide only routine preventative care.

## 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 Michigan proposal. Following the submission of the proposal, CMS asked MDCH 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.

<b>Standard/ Condition</b>	<b>Standard/Condition Description</b>	<b>Location in proposal (i.e., page #)</b>
<b>Integration of Benefits</b>	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 15-16, addendum
<b>Care Model</b>	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 10-18, addendum
<b>Stakeholder Engagement</b>	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, beneficiary organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 18-21

	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. 22, 30
<b>Enrollee Protections</b>	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure enrollee health and safety and enrollee access to high quality health and supportive services necessary to meet the enrollee’s needs. At a minimum, States will be required to:	pp. 21-22, 30-31
	<ul style="list-style-type: none"> <li>• Establish meaningful enrollee input processes which may include enrollee participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of enrollee advisory boards).</li> </ul>	pp.22
	<ul style="list-style-type: none"> <li>• Develop, in conjunction with CMS, uniform/integrated enrollee materials that are accessible and understandable to the enrollees, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.</li> </ul>	pp. 21
	<ul style="list-style-type: none"> <li>• Ensure privacy of enrollee health records and provide for access by enrollees to such records.</li> </ul>	pp. 12
	<ul style="list-style-type: none"> <li>• Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.</li> </ul>	pp. 12 – 14

	<ul style="list-style-type: none"> <li>• Ensure access to services in a manner that is sensitive to the enrollee’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately.</li> </ul>	pp. 16
	<ul style="list-style-type: none"> <li>• Ensure an adequate and appropriate provider network, as detailed below.</li> </ul>	pp. 16-17
	<ul style="list-style-type: none"> <li>• Ensure that enrollees are meaningfully informed about their care options.</li> </ul>	pp. 12
	<ul style="list-style-type: none"> <li>• Ensure access to grievance and appeals rights under Medicare and/or Medicaid.</li> </ul>	pp. 21-22
	<ul style="list-style-type: none"> <li>o <i>For Capitated Model</i>, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.</li> </ul>	pp. 21-22
	<ul style="list-style-type: none"> <li>o <i>For Managed FFS Model</i>, MDCH will ensure a mechanism is in place for assisting the enrollee in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.</li> </ul>	N/A
<b>State Capacity</b>	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp.26-29, 31
<b>Network Adequacy</b>	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 16-17

<b>Measurement/ Reporting</b>	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model’s quality and cost outcomes for the target population. These metrics may include, but are not limited to enrollee experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote enrollees receiving high quality care and for purposes of the evaluation.	pp. 24-25
<b>Data</b>	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	<ul style="list-style-type: none"> <li>• Enrollee level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;</li> </ul>	pp. 27
	<ul style="list-style-type: none"> <li>• Description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and</li> </ul>	N/A
	<ul style="list-style-type: none"> <li>• State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.</li> </ul>	pp. 29
<b>Enrollment</b>	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 29-30

<b>Expected Savings</b>	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp. 26
<b>Public Notice</b>	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> <li>• At least a 30-day public notice process and comment period;</li> </ul>	pp. 18-21
	<ul style="list-style-type: none"> <li>• At least two public meetings prior to submission of a proposal; and</li> </ul>	pp. 18-21
<b>Implementation</b>	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	<ul style="list-style-type: none"> <li>• Meaningful stakeholder engagement.</li> </ul>	pp. 18-21
	<ul style="list-style-type: none"> <li>• Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.</li> </ul>	pp.18, 31
	<ul style="list-style-type: none"> <li>• Receipt of any necessary State legislative or budget authority.</li> </ul>	pp. 32
	<ul style="list-style-type: none"> <li>• Joint procurement process (for capitated models only).</li> </ul>	pp. 12
<ul style="list-style-type: none"> <li>• Beneficiary outreach/notification of enrollment processes, etc.</li> </ul>	pp. 30-31	

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

The Demonstration Area consists of 25 counties grouped into four regions, as highlighted in the map below.

Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft

Region 4: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren

Region 7: Wayne

Region 9: Macomb



## 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 ICOs and their sponsoring organizations for the Demonstration period beginning no earlier than no earlier than January 1, 2015 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the three-way contracts.

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

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

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 C.F.R. §422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in ICOs to Medicare-Medicaid eligible individuals only insofar as such provisions are consistent with eligibility criteria in section III.C., 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 C.F.R. §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 and enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 C.F.R. §422.2266 and §423.2266, with respect to marketing and enrollee communications materials in categories of materials that CMS and MDCH have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and MDCH have agreed to approval.
- Sections 1852 (f) and (g) and implementing regulations at 42 C.F.R. §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 C.F.R. §423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit ICOs to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

## **Appendix 5: Medicaid Authorities and Waivers**

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning no earlier than January 1, 2015 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the three-way contracts.

This Demonstration and the additional authority referenced below are contingent upon submission and approval of all documentation necessary to demonstrate compliance with: the Medicaid requirements under 42 C.F.R. Parts 438 and 441 for enrollment of the Demonstration population into managed care as specified in the Social Security Act Section 1915(b); and necessary home and community based waiver requirements as specified by concurrent Social Security Act Section 1915(c) authority. MDCH must meet all requirements of any approved Medicaid waiver authority as expressed in the terms of those waivers, including, but not limited to, all financial, quality, reporting and monitoring requirements of the waiver, and State financing contained in MDCH's waiver must be in compliance with federal requirements. To date, CMS has not received from MDCH a 1915(b) or 1915(c) waiver application. This MOU does not indicate or guarantee CMS approval of the Section 1915(b) and 1915(c) waivers.

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

### **1115A Medicaid Waivers**

Under the authority of Section 1115A of the Social Security Act the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to enable MDCH to carry out the Demonstration to Develop an Integrated Care Delivery System for dual eligible individuals. These authorities shall be in addition to those in the State Plan and the Section 1915(b) and 1915(c) waivers.

### **Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 C.F.R. §438.6)**

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

## Appendix 6: Payments to ICOs

The Centers for Medicare and Medicaid Services and MDCH will enter into a joint rate-setting process based on the following principles:

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

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

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

<b>Demonstration Year</b>	<b>Calendar Dates</b>
1	January 1, 2015 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

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

<b>Rate Element</b>	<b>Medicare A/B</b>	<b>Medicare D</b>	<b>Medicaid</b>
<p><b>Baseline costs for the purposes of setting payment rates</b></p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and MDCH determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	<p>Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service (FFS) weighted by where Medicare-Medicaid enrollees who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.</p>	<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 low-income subsidy (LIS) payments, reinsurance payments, and risk-sharing are included in the Part D baseline for the purposes of tracking and evaluating Part D costs but not for the purposes of setting payment rates. These amounts will be factored into ICO payments, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.</p>	<p>Blend of (a) Medicaid fee-for-service claims for services to be covered in the Demonstration and (b) capitation payments associated with those eligible individuals in Medicaid managed care today (i.e., who gained Medicare eligibility but chose to remain with their prior Medicaid health plan), subject to CMS review.</p>
<b>Responsible for producing data</b>	CMS	CMS	Michigan Medicaid, validated by CMS
<b>Savings percentages</b>	<p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 4%</p>	Not Applicable	<p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 4%</p>

Rate Element	Medicare A/B	Medicare D	Medicaid
<b>Risk adjustment</b>	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	Tiered rates based on level of care, as described in Section IV below
<b>Quality withhold</b>	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%
<b>Risk Sharing</b>	Combined (all eligible costs except Part D) ICO-level tiered risk corridors for Demonstration Year 1, as referenced in section IX. Minimum Medical Loss Ratio (MMLR) for Demonstration Years 2 and 3.  This risk sharing does not apply to the services separately funded through direct payment from the State to the PIHPs.	Existing Part D processes will apply	Combined (all eligible costs except Part D) ICO-level tiered risk corridors for Demonstration Year 1, as referenced in section IX. MMLR for Demonstration Years 2 and 3.  This risk sharing does not apply to the services separately funded through direct payment from the State to the PIHPs.

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

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

### **A. Medicaid:**

1. Prior to implementation of the Demonstration, and subject to CMS approval, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration. The State and its actuaries will identify the Medicaid costs associated with beneficiaries in the target population for this Demonstration.
  - i. The largest component of the Medicaid baseline costs will be based on Michigan fee-for-service costs provided via FFS absent the Demonstration. The data sources for this Medicaid component of the rate for the first Demonstration year are based on Michigan fee-for-service claims for calendar years 2010 through 2013. Updates to this component of the rate for Demonstration Years 2 and 3 will use updated Michigan fee-for-service data, as available at the point of rate-setting for each Demonstration year.
  - ii. For the portion of enrollees expected to transition from the State's 1915(b) Medicaid capitated program to the Demonstration, the Medicaid baseline costs will be based on the 1915(b) capitation payments that would be in effect in absence of the Demonstration.
2. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).
3. The State and its actuaries will continue to update the baseline cost for this Demonstration to reflect changes and/or adjustments that are made to the 1915(b) capitation rates outside of the Demonstration. Except for these updates and those based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS determines the update would result in a substantial change

to the baseline necessary to calculate accurate payment rates for the Demonstration.

4. Medicaid payment rates will be determined by applying annual savings percentages (see section II and III) to the applicable baseline spending amounts.

B. Medicare Part A/B:

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

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.

- c. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section II and III) to the baseline spending amounts.
- d. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized payment rates at the time of payment.
- e. CMS may require MDCH to provide a data file for enrollees who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.

- f. The Medicare portion of the baseline will be updated annually consistent with the annual Fee-For-Service (FFS) estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
- g. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2014 is 4.91%. The majority of new ICO enrollees will come from Medicare FFS, and 2015 risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the ICOs themselves. In calendar year 2015, CMS will apply an appropriate coding intensity adjustment based on the expected 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 proportional to the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based 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 ICO enrollees.

C. Medicare Part D:

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

The CY 2014 Part D NAMBA is \$75.88. CMS will publish the CY 2015 NAMBA in August of 2014.

## **II. Aggregate Savings Percentages under the Demonstration.**

- A. Both parties agree that there is reasonable expectation for achieving savings while paying ICOs capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to enrollee needs.
- B. The savings percentages will be:

1. Demonstration Year 1: 1%
2. Demonstration Year 2: 2%
3. Demonstration Year 3: 4%

C. Rate updates will take place on January 1<sup>st</sup> of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

**III. Application of Aggregate Savings Percentages to Medicare A/B and Medicaid Components of the Integrated Rate**

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

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

**IV. Rate Structure and Risk Adjustment Methodology for the Medicaid Component of the Rates**

A. The rating categories to be utilized for the Medicaid component of the rates in the Demonstration are described below.

**Figure 6-3: Medicaid Component Rate Cells**

<b>Rating Category Rate Cell</b>	<b>Description</b>
Tier 1	<ul style="list-style-type: none"> <li>• Enrollees who on the first day of the month, (1) meet the nursing facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (LOCD) tool, and (2) occupy a nursing facility bed certified for both Medicare and Medicaid.</li> <li>• Rates may vary by age.</li> <li>• Rates will vary for the four contracting regions.</li> </ul>

	<ul style="list-style-type: none"> <li>• Separate rates will be paid for publicly owned and privately owned nursing facilities.</li> </ul>
Tier 2	<ul style="list-style-type: none"> <li>• Enrollees who, on the first day of the month, (1) meet the nursing facility level of care as determined by the Michigan Nursing Facility LOCD tool, (2) live in any setting other than that referenced in Tier 1, and (3) are enrolled in the ICO 1915(c) waiver.</li> <li>• Rates may vary by age.</li> <li>• Rates will vary for the four contracting regions.</li> </ul>
Tier 3	<ul style="list-style-type: none"> <li>• Enrollees who do not meet the criteria for Tier 1 or Tier 2 on the first day of the month.</li> <li>• Rates may vary by age.</li> <li>• Rates will vary for the four contracting regions.</li> </ul>

- a. No less than annually, MDCH will monitor ICOs for unanticipated increase in the number of enrollees meeting the nursing facility level of care standard. If the findings show increased numbers of LOC approvals compared to the assumptions used to create the rate cells, MDCH will prospectively adjust rate cell payment levels or make other changes to the rate structure, subject to CMS approval, to achieve budget neutrality relative to baseline costs. Also, if MDCH makes changes to the nursing facility level of care process during the course of the Demonstration, those changes will be incorporated into the three-way contract.
- b. All NFLOC determinations are subject to audit by MDCH, CMS, or their authorized representatives.
- c. Rates Following a Transition
  - i. Up to three months following the transition of a Tier 2 or Tier 3 enrollee into a nursing facility, payment will be based on the Tier 2 or Tier 3 rate.
  - ii. A transition case rate will be paid after the transition of a Tier 1 enrollee into a community setting. In order for the transition to qualify for the case rate, the ICO must have been paid three consecutive Tier 1 capitation payments for the individual. The ICO must provide transitional services for the enrollee in order to receive the case rate.

## **V. Risk Adjustment Methodology for Medicare Components of the Rates**

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

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

- A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to ICO performance, which includes PIHP responsibilities identified in the contract between the ICO and PIHP, 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. These measures and incentives support shared accountability for the whole person. Improved outcomes are most likely to occur when each provider considers and acts on the identified and shared goals.

All ICO subcontracts with PIHPs must include provisions that reward the PIHP when the ICO achieves the withheld amounts. This may be accomplished by applying the same percentage withhold to the payments from ICOs to PIHPs, subject to the same withhold criteria. MDCH will phase-in a separate quality withhold process specific to PIHP performance following the first year of the Demonstration. The PIHP process will be based on established quality thresholds and be repaid subject to PIHP performance in the Demonstration. Any separate PIHP withhold will be defined in the contract between MDCH and the PIHPs.

- B. Withhold Measures in Demonstration Year 1.

Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the three-way contract.

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

<b>Domain</b>	<b>Measure</b>	<b>Source</b>	<b>CMS Core Withhold Measure</b>	<b>State Specified Measure</b>
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of enrollees with initial assessments completed within 90 days.	CMS/State defined process measure	X	X
Governance board	Establishment of enrollee advisory board or inclusion of enrollees on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed.</p> <ul style="list-style-type: none"> <li>• In the last 6 months, how often did your health plan’s customer service give you the information or help you needed? •</li> <li>• In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect?</li> <li>• In the last 6 months, how often were the forms for your health plan easy to fill out?</li> </ul>	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly enrollees get appointments and care	AHRQ/CAHPS	X	

	<ul style="list-style-type: none"> <li>• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? •</li> <li>• In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</li> </ul>			
Care Transition Record Transmitted to Health Care Professional	Percent of Demonstration enrollees 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 to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI		X
Care for Older Adults - Medication Review	Percent of plan 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
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure		X

C. Withhold Measures in Demonstration Years 2 and 3.

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

Demonstration and State specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2 and 3.

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

Domain	Measure <sup>2</sup>	Source	CMS Core Withhold Measure	State Specified 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 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages 21 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X
Reducing the risk of falling	Percent of enrollees with a problem falling, walking or	NCQA/HEDIS HOS	X	

<sup>2</sup> For age specific measures, the language reflects what is currently in the published technical specifications. However, only persons eligible for and enrolled in the demonstration will be included in the calculations.

	balancing who discussed it with their doctor and got treatment for it during the year.			
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	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	X
Care Transition Record Transmitted to Health Care Professional	Percent of Demonstration enrollees 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 to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI		X
Medication Review – All Populations	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	State-defined (HEDIS-like)		X
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Urinary Tract	Percent of enrollees	CMS/State		X

Infection	(specified population) with urinary tract infections.	defined process measure		
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(Note: Part D payments will not be subject to a quality withhold, however ICOs will be required to adhere to quality reporting requirements that currently exist under Part D.)

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

**VII. Payments to ICOs.**

- A. CMS will make separate monthly risk-adjusted payments to the ICOs for the Medicare Parts A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.
- B. The State will make a payment to the ICOs for the Medicaid component of the rate subject to the rate structure specified in Section IV.
- 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 enrollees’ Individual Integrated Care and Supports Plans. CMS and MDCH will jointly monitor access to care and overall financial viability of ICOs accordingly.

**VIII. Evaluate and Pay ICOs Relative to Quality withhold Requirements.**

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

**IX. Minimum Loss Ratio, Reconciliation, and Rate Review**

- A. **Risk Corridor:** Risk corridors will be established for Demonstration Year 1 in order to account for possible enrollment bias and to protect ICOs and payers against uncertainty in rate-setting that could result in either overpayment or underpayment until actual

program experience is available. Risk corridors will not be applied for Demonstration Years 2 or 3. The Demonstration will utilize a tiered ICO-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible costs. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g., CMS-HCC). Risk corridors will be reconciled as if all ICOs had received the full quality withhold payment. The three-way contract will include further details on how risk corridors will be operationalized under this Demonstration.

- a. Process for collecting cost information: CMS and MDCH will evaluate encounter data, cost data, and ICO financial reports to determine ICO incurred costs of services and care coordination/management.
- b. Risk corridor share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Part D, with the maximum Medicare payment/recoupment equaling 2% of the risk-adjusted Medicare baseline. All remaining payments or recoveries once Medicare has reached its maximum shall be treated as Medicaid expenditures eligible for FMAP. Risk corridors will consider both service and care management costs.
- c. Risk corridor tiers: CMS and MDCH will use the bands as described in Figure 6-5 to address potential ICO gains/losses in Demonstration Year 1:

**Figure 6-5: Risk Corridor Tiers**

<b>Net Income Before Taxes as a % of Revenues</b>	<b>ICO Share</b>	<b>Medicare Share</b>	<b>MDCH Share</b>
≤ 3%	100%	0%	0%
>3% and ≤ 9%	50%	Percentage based on Medicare share of combined capitation payments, excluding Part D	Percentage based on Medicaid share of combined capitation payments, excluding Part D
>9%	100%	0%	0%

- B. **Minimum Loss Ratio:** Beginning Demonstration Year 2, each ICO will be required each year to meet a Minimum Medical Loss Ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments after final risk adjustment) that must be used for expenses either directly related to covered services or those which are related to the care of and quality improvement for enrollees.

If an ICO has an MMLR below 85% of the joint Medicare and Medicaid payment to the ICOs, the ICO must remit the amount by which the 85% threshold exceeds the plan's actual MMLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

The three-way contracts will include additional specifications on the MMLR. To the maximum extent possible, the methodology for calculating the MMLR will conform to prevailing regulatory requirements (e.g., 42 C.F.R. §§ 422.2400 et seq. and 423.2400 et seq.) applicable to the others products offered by organizations operating ICOs.

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

In Demonstration Years 2 and 3, CMS and the MDCH will review the rates and payment parameters if two or more ICOs show MLRs below 90% over all regions in which those plans participate, or in the event that two or more ICOs show annual losses exceeding 5% over all regions in which those plans participate.

- E. **Savings Percentage Adjustment:** In the event that at least one-third of ICOs experience losses in Demonstration Year 1 exceeding 3% of revenue, the savings percentage for Demonstration Year 3 will be reduced to 3%. CMS and the State will make such a determination at least four months prior to the start of Demonstration Year 3.

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

- A. Rates will be updated using a similar process for each calendar year. Changes to the baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and MDCH 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 MDCH prior to making any adjustment, but MDCH concurrence will not be required. Changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in federal law and/or State law or policy compared to assumptions about federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity. CMS and/or MDCH will make changes to baseline estimates within 30 days of identification of the need for such changes, and changes will be applied on a retrospective basis, if necessary, to effectuate accurate payment rates for each month.
  
- B. Changes to the savings percentages would occur if and when CMS and MDCH jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

## **Appendix 7: Demonstration Parameters**

The purpose of this appendix is to describe the parameters that will govern this Demonstration; the parameters are based upon those articulated by CMS in its January 9, 2013 Health Plan Management System (HPMS) guidance. CMS and MDCH 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. Michigan Department of Community Health Delegation of Administrative Authority and Operational Roles and Responsibilities**

The Michigan Medical Services Administration (MSA, or Michigan Medicaid) within the Michigan Department of Community Health is the single state agency for the Medicaid program. The Michigan Medicaid Director oversees Medicaid operations and will be involved with implementing and monitoring the Demonstration. Within MSA, the Bureau of Medicaid Policy and Health Systems Innovation contains the Integrated Care (IC) Division. The IC Division Director will have overall responsibility for continued development and implementation of the Demonstration and will serve as the main point of contact for the Medicare Medicaid Coordination Office at CMS.

The Demonstration Steering Committee will provide high level policy input into the Demonstration and serve as the primary communication channel to the MDCH Director. Steering Committee members include representatives from the Behavioral Health and Developmental Disabilities Administration and the Office of Services to the Aging within MDCH; from within MSA the Bureau of Medicaid Policy and Health Systems Innovation, the Bureau of Medicaid Operations and Quality Assurance, the Bureau of Medicaid Payments and Administrative Services, the Office of Medicaid Health Information Technology and the Office of Medical Affairs are represented. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across Michigan Medicaid including the Integrated Care Division, the Actuarial Division, the Long Term Care Services Division, the Managed Care Plan Division, and the Pharmacy Management Division.

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

In consultation with CMS, the State released a request for proposals (RFP) that included

Michigan and CMS requirements for organizations to become ICOs under this Demonstration. Michigan's RFP was posted on the following website:

<https://www.buy4michigan.com/bs0/external/bidDetail.sdo?bidId=0071141113B0000292&parentUrl=activeBids>

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

Selection of ICOs and subsequent participation in the Demonstration is contingent on the selected entities passing a CMS and state sponsored readiness review. Upon final selection and successful completion of the readiness review, MDCH and CMS will ultimately enter into a three-way contract with selected plans. As a condition of participation, selected entities must not be [under sanction by CMS within Michigan](#).

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

### **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 ICO to a different ICO, will be processed through the Michigan Enrollment Broker, except those transactions related to non-Demonstration plans participating in Medicare Advantage. Michigan Medicaid (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to Michigan Medicaid identifying individuals who have elected a Medicare Advantage plan that is not an ICO. CMS will also submit a file to Michigan Medicaid identifying individuals who called 1-800-MEDICARE and chose to opt-out. Michigan Medicaid will share enrollment, disenrollment and opt-out transactions with contracted ICOs and Prepaid Inpatient Health Plans (PIHPs).
- c. Uniform Enrollment/ Disenrollment and Opt-Out Letter and Forms - Letters and forms will be made available to stakeholders by both CMS and MDCH.

- d. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollment is effective the first calendar 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 enrollee. MDCH will conduct phased in periods for opt-in and passive enrollment.
  - i. Opt-in: The State will initially conduct two phased opt-in periods. ICOs will be required to accept opt-in enrollments no earlier than 30-days prior to the initial effective date as outlined below. Opt-in enrollments will be phased in prior to passive enrollment.
    - a) Phase 1: Beneficiaries in Region 1 (Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties) and Region 4 (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren counties) will be able to opt in beginning no earlier than October 1, 2014 with an enrollment effective date of January 1, 2015.
    - b) Phase 2: Beneficiaries in Region 7 (Wayne County) and Region 9 (Macomb County) will be able to opt in no earlier than March 1, 2015 with an enrollment effective date of May 1, 2015.

The State or the Michigan Enrollment Broker will provide notice of the opportunity to select an ICO at least 30 days prior to the effective date of an opt-in enrollment period. This notice will explain the beneficiary's options, including the option to opt out of the Demonstration at any time.

- ii. Passive: MDCH will initially conduct two passive enrollment phase-in periods for those beneficiaries who have not made a plan selection. Passive enrollment is effective no sooner than 60 days after beneficiary notification of the right to select an ICO. The start dates for the first two of these periods are tentatively as follows:
  - a) Phase 1: Beneficiaries in Regions 1 and 4 will have a passive enrollment effective date of no earlier than April 1, 2015.
  - b) Phase 2: Beneficiaries in Regions 7 and 9 will have a passive enrollment effective date of no earlier than July 1, 2015.

The State or the Michigan Enrollment Broker will provide notice of the opportunity to select an ICO 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. The 60-day notice will explain the beneficiary's options, including the option to opt out of or disenroll from the Demonstration. The notice will include the name of the ICO in which the beneficiary would be enrolled unless he/she selects another plan or chooses to opt out of the Demonstration.

Thirty days prior to the passive enrollment effective dates above, a second notice will be provided to beneficiaries who have not responded to the initial notice. Michigan will proceed with passive enrollment into the identified ICO for beneficiaries who do not make a different choice, with an effective date of the first day of the month referenced in section d.ii, above.

- iii. Beneficiaries subject to Medicare reassignment effective January 1, 2015, either from their Medicare Prescription Drug Plan (PDP) or Medicare Advantage Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment during CY 2015. However, those 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 an ICO effective no earlier than January 1, 2016.

The effective dates above are subject to ICOs meeting CMS and State requirements including Plans' capacity to accept new enrollees.

Plans designated by CMS as a past performance outlier or identified as "consistently low performing" based on the performance of the parent and/or sibling organizations, will not receive passive enrollments.

In addition, if a plan is not meeting certain standards, then passive enrollments may be stopped by either CMS or MDCH.

- iv. Requests to disenroll from an ICO, opt out, or enroll in a different ICO will be accepted at any point after an individual's initial enrollment occurs and are effective on the first of the month following receipt of request. Any time an individual requests to opt out of passive enrollment or disenrolls from the Demonstration, MDCH or the Michigan Enrollment Broker will send a letter confirming the opt-out and providing information on the benefits available to the beneficiary once he or she has opted out or disenrolled.

- v. When a beneficiary becomes eligible for the Demonstration after the phase-in is complete (e.g., ages in, or moves into one of the Demonstration regions, etc.) he or she will receive a letter detailing enrollment options. If the beneficiary is also eligible for passive enrollment, he or she will have a minimum of 60 days to make a choice to enroll or disenroll or be passively enrolled.
- e. No enrollments will be accepted within 6 months of the end of the Demonstration.
- f. Notification of plan selection and enrollment options will be provided by MDCH or the Michigan Enrollment Broker to each beneficiary not less than 60 calendar days prior to the effective date of the proposed enrollment.
- g. The State is developing an “assignment” algorithm for passive enrollment. The algorithm will, at a minimum, consider beneficiaries’ previous managed care enrollment, in both Medicare Advantage plans and Medicaid managed care, and enrollments of people who share a common case number for Medicaid eligibility. MDCH will include additional ICO measures for quality, administration, and capacity in the algorithm as data becomes available.
- h. The State and/or the Michigan Enrollment Broker 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. In addition to the Enrollment Broker, the Michigan Medicare-Medicaid Assistance Program (MMAP) will provide eligible individuals, family members, and other stakeholders direct outreach and education presentations, peer-to-peer options counseling, and maintain on-going capacity for outreach, education and options counseling. The MMAP will build upon its partnership with Michigan’s Area Agencies on Aging and work with other information and assistance providers, such as senior centers and Centers for Independent Living. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare beneficiaries; calls related to Demonstration enrollment will be referred to the Michigan Enrollment Broker for customer service and enrollment support.
- i. CMS and MDCH will jointly approve all Demonstration enrollment notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).

- j. State and CMS systems will be reconciled daily and on a timely basis to resolve discrepancies between systems.

The State and CMS must agree in writing to any changes to the enrollment effective dates.

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

- a. State Requirements for Care Coordination –The ICOs will develop and implement a strategy that uses a combination of initial screenings, assessments, health risk assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of care coordination needed by each enrollee. ICOs may also choose to use existing predictive modeling software to support the screening and assessment requirements but will not be required to do so. Care Coordination services will be available to all ICO enrollees.

ICOs will be required to contract with Prepaid Inpatient Health Plans (PIHP) to jointly coordinate and manage care for enrollees with behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD) needs. The ICO-PIHP contract will be monitored by MDCH to ensure ICOs meet all delivery system requirements of the Demonstration and all enrollees receive the appropriate care coordination services.

- i. Care Bridge: The Care Bridge is the care coordination framework for the Demonstration. Through the Care Bridge, the members of the enrollee’s care and supports team facilitate access to formal and informal services and supports identified in the enrollee’s Individual Integrated Care and Supports Plan (IISCP) developed through a person-centered planning process. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the care and supports team.

The Care Bridge requirements are based on the following:

- The ICO is responsible to provide care coordination services to the enrollee in accordance with the enrollee’s individual preferences as determined through the person-centered planning process.
- Care coordination services will provide for:
  - A person-centered, outcome-based approach, consistent with the CMS model of care (MOC) and Medicare and Medicaid requirements and guidance.

- The opportunity for the enrollee to choose arrangements that support self-determination.
  - 
  - Appropriate access and sharing of information. Enrollees and treating providers will have access to all the information in the Integrated Care Bridge Record (ICBR). It is the Enrollee's right to determine the appropriate involvement of other members of the ICT in accordance with applicable privacy standards.
  - Medication review and reconciliation.
- ii. **Assessment Process:** The assessment process includes three steps: 1) Initial Screening using specified screening questions at the time of enrollment; 2) completion of the Level I Assessment using an approved tool; and 3) the Level II Assessment for enrollees identified as having needs related to LTSS, BH, SUD, or I/DD services or complex medical needs.

The assessment process must be completed for all persons who enroll in the Demonstration. Existing assessments and person-centered service plans or plans of care can be incorporated into the assessment and IICSP. ICOs must have policies and procedures in place for staff to document when the enrollee refuses to participate in the assessment process.

### **Initial Screening**

The ICO will review the enrollee's responses to the initial screening questions collected at the time of enrollment by Michigan's Enrollment Broker. This initial screening is a series of enrollee reported yes/no questions related to historical and current service use. The purpose of the initial screening is to identify enrollees with immediate needs in order to prioritize in person Level I Assessments.

The initial screening will be conducted via telephone when individuals call the Enrollment Broker to enroll in the Demonstration. The initial screening questionnaire will also be included in mailing packets for those individuals who do not choose telephonic enrollment. Results of the initial screening will be sent to the ICO by MDCH in the 834 enrollment file.

In addition to reviewing initial screening responses, the ICO is required to review program level data (from the MDCH MMIS system, CHAMPS) and past utilization data from the MDCH Data Warehouse as part of the initial screening process.

The ICO must review initial screening responses, program level data, and utilization data within 15 calendar days of enrollment. If initial screening results are not available, the ICO is required to conduct the initial screening via telephone or in person within 15 calendar days of enrollment.

At the time of the Readiness Review, the ICO will submit policies and procedures that demonstrate preparedness for implementing the above requirements.

### **Level I Assessment**

The ICO will conduct a Level I Assessment, using an MDCH approved tool, to assess each enrollee's current health, welfare, and functional needs and risks. This tool must include the following domains:

1. Individual preferences, strengths, and goals including self-determination arrangements
2. Natural supports, including family and community caregiver capacity and social strengths and needs
3. Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and enrollee health literacy
4. Current services, including those covered by Medicare and Medicaid, local services, and care transition needs
5. Medical health risk, status, and history, including but not limited to medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections
6. BH and SUD risk status; BH, SUD, and I/DD history and needs, including medications
7. Nutritional strengths and needs
8. Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs
9. Cognitive strengths and needs
10. Long-term services and supports
11. Quality of life including physical, mental, and psycho-social well-being, abuse, neglect, or exploitation

This assessment will serve as the basis for identifying need for the Level II

assessment and referral that focus more specifically on LTSS, BH, SUD, I/DD and complex medical needs. The ICO will identify, through the Level I Assessment, enrollees who may require institutional level of care. Further assessment using the Michigan Medicaid Nursing Facility Level of Care tool is necessary to determine eligibility for Waiver or Medicaid nursing facility services.

The ICO will coordinate with the primary care provider to ensure that enrollees with complex medical needs identified in the Level I Assessment have further follow-up relevant to these needs.

The Level I Assessment will be conducted by an ICO Care Coordinator. The enrollee will have a choice of care coordinator. The ICO will include the appropriate PIHP or LTSS Supports Coordinator or nursing facility in conducting the assessment if the enrollee is active in the PIHP or LTSS system during the previous 12 months. Family members or other individuals may also be included in the assessment process to the extent desired by the enrollee. The ICO Care Coordinator is responsible for assuring completion of in-depth assessments of persons with medically complex conditions.

The ICO will conduct the Level I Assessment based on available information, within 45 calendar days of enrollment. The ICO is encouraged to conduct the Level I Assessment in person. Enrollees identified with immediate needs or as having high risk should have assessments completed in person earlier than 45 days, as appropriate.

## **Level II Assessment**

Based on the findings from the Level I Assessment, the ICO will collaborate with the regional PIHP to ensure that the Level II Assessment is conducted for enrollees identified as having BH or I/DD needs. Likewise, the ICO will ensure that the Level II Assessment is conducted for enrollees demonstrating LTSS needs identified in the Level I Assessment.

The Level II Assessment tools will be determined by MDCH.

Level II Assessments will be conducted by professionally knowledgeable and trained staff – such as LTSS Supports Coordinators or assigned PIHP Supports Coordinators or Case Managers – who have experience working with the population. Level II Assessments will be conducted in-person within 15 days of completion of the Level I Assessment. Details of assessment timeframes will be outlined in the contract between the ICO and PIHP.

## **Level I and Level II Assessment Policies and Procedures**

At the time of the Readiness Review, ICOs will submit to MDCH and CMS all policies and procedures that address the following for Level I and Level II assessments:

1. Meeting the required assessment timeframes
  2. Contacting the enrollee within the required assessment timeframes. This may require repeated attempts, including collaborating with service providers, all of which should be documented.
  3. Making assessment materials available upon request in the enrollee's preferred written or spoken language and/or alternate formats that effectively communicate the information.
  4. Including appropriate involvement of caregivers, family members, and/or other allies, and obtaining the enrollee's consent when the desire for such involvement is identified.
  5. Identifying the enrollee's medical care and supportive service needs, including those for primary care, specialty care, durable medical equipment (DME), assistive devices, medications, LTSS, HCBS, BH and I/DD, and SUD, and other necessities and preferences that will inform the development of an Individual Integrated Care and Supports Plan (IICSP).
  6. Identifying and assessing the need for other activities, services, and supports to assist enrollees in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve the quality of life and the ability to live in the community.
  7. Utilizing the Care Coordination platform to incorporate assessment results into the Integrated Care Bridge Record (ICBR) within five days of completion.
  8. Collaborating with PIHPs, the LTSS representative, and the nursing facility representative, as applicable, in conducting the Level I Assessment.
- iii. Reassessment and Review: The ICO is responsible to ensure that an annual reassessment for each enrollee (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within 12 months of the last assessment. If prior to the annual reassessment, the enrollee experiences a major change impacting health status, the ICO is required to reassess the enrollee, review, and revise the IICSP as needed. The ICO is responsible to complete an assessment as often as desired by the enrollee and update the IICSP as needed. ICOs are encouraged to conduct reassessments in-person.

The ICO Care Coordinator will regularly monitor the Integrated Care Bridge Record, utilization data from the MDCH Data Warehouse, and other appropriate information that may reflect the enrollees' health status. The ICO will identify changes in conditions or utilization of services for all enrollees, including, but not limited to newly-diagnosed acute and chronic conditions, high frequency of emergency department visits, hospitalizations, and LTSS or BH, SUD, and I/DD referrals.

For enrollees receiving Nursing Facility Level of Care services, the reassessment must confirm that the enrollee continues to meet the Michigan Medicaid Nursing Facility Level of Care standards. If the standards are not met, the ICO will initiate planning for transitioning the enrollee to more appropriate services and supports.

- iv. Integrated Care Team (ICT): ICOs will comply with the following requirements regarding ICTs:
- An ICT will be offered to the enrollee. The ICT will honor the enrollee's choice about his or her level of participation. This choice will be revisited periodically by the ICO Care Coordinator as it may change. The ICO Care Coordinator will be the lead of the ICT. Membership will also include the enrollee and the enrollee's chosen allies, primary care physician, and LTSS Supports Coordinator and/or PIHP Supports Coordinator (as applicable). The team may also include the following persons as needed and available:
- Family caregivers and natural supports
  - Primary care nurse care manager
  - Specialty providers
  - Paid supports
  - Hospital discharge planner
  - Nursing facility representative
  - Others as appropriate.

The role of ICT is to work collaboratively with the enrollee and other team members to ensure the IISCP is fulfilled according to the person-centered planning process and the enrollee's stated goals. Team members will:

- Participate in the person-centered planning process at the enrollee's discretion
- Collaborate with other ICT members to ensure the person-centered planning process is maintained
- Assist the enrollee in meeting his/her goals
- Monitor and ensure that their part of the IISCP is implemented in order to meet the enrollee's goals

- Update the ICBR as needed pertinent to the team member's role on the ICT
- Review assessment, test results and other pertinent information in the ICBR
- Address transitions of care when a change between care settings occur
- Ensure continuity of care
- Monitor for issues related to quality of care and quality of life

The operations of ICTs will vary depending on the needs and preferences of the enrollee. An enrollee with extensive service needs may warrant periodic meetings with all team members. An enrollee with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with members.

The ICT will adhere to an enrollee's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for patients in substance use disorder treatment, C.F.R. 42, Part 2.

- v. Responsibilities and Qualification of the ICO Care Coordinator: The ICO Care Coordinator will be responsible for care coordination for each enrollee. The ICO Care Coordinator will conduct the Level I Assessment, assure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT. ICO Care Coordinators must meet the following qualifications and coordinate the following activities with the PIHP Supports Coordinator or LTSS Supports Coordinator and ICT members as appropriate:

The ICO Care Coordinator must be a Michigan licensed registered nurse, nurse practitioner, physician's assistant, or Bachelor's or Master's prepared social worker.

The ICO Care Coordinator will be responsible to:

- Support an on-going person-centered planning process
- Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and a Level II Assessment (as appropriate)
- Facilitate timely access to primary care, specialty care, BH, SUD, and I/DD services, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers

- Create and maintain an Integrated Care Bridge Record (ICBR) for each enrollee to manage communication and information regarding referrals, transitions, and care delivery
- Meeting of the Integrated Care Team (ICT), as needed or as requested by the enrollee
- Facilitate communication among the enrollee’s providers through the use of the Care Coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence
- Notify ICT of the enrollee’s hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable
- Facilitate face-to-face meetings, conference calls, and other activities of the ICT
- Facilitate direct communication between the provider and the enrollee
- Facilitate enrollee and family education
- Coordinate and communicate with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative services and supports are provided
- Develop, with enrollee and ICT, an IICSP specific to individual needs, and monitor and update the plan at least annually or following a significant change in needs or other factors
- Coordinate and make referrals to community resources (e.g. housing, home delivered meals, energy assistance programs) to meet IICSP goals
- Perform ongoing care coordination, facilitating access to services, monitoring and advocacy
- Monitor the implementation of the IICSP with the enrollee
  - Facilitate the enrollee’s evaluation of the process, progress and outcomes
  - Identify barriers and facilitate problem resolution and follow-up
- Advocate with or on behalf of the enrollee as needed, to ensure successful implementation of the IICSP
- Support transitions in care when the enrollee moves between care settings
- Engage in other activities or services needed to assist the enrollee in optimizing his or her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status
- Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits

- If the enrollee is receiving services that require meeting the Nursing Facility Level of Care standards, assure that the enrollee continues to meet the criteria or transitions to services that do not require NFLOC standards. ICOs are required to conduct the NFLOC assessment for enrollees with identified long-term care needs.

At the time of Readiness Review, the ICO will submit policies and procedures related to the roles and responsibilities of the ICO Care Coordinator, subject to the approval of MDCH and CMS.

The ICO Care coordinator must collaborate with the applicable PIHP Supports Coordinator as defined in the contract between the ICO and the regional PIHP when:

- The enrollee has received services through a PIHP within the last 12 months, or
- A newly enrolled person requests or is identified as having potential need for BH, I/DD, or SUD services.
- If the enrollee has need of LTSS, the ICO Care Coordinator will collaborate with the enrollee's chosen LTSS Supports Coordinator.

- vi. Responsibilities and Qualifications of LTSS Supports Coordinator: LTSS Supports Coordinator will be offered to all enrollees who meet Michigan Medicaid Nursing Facility Level of Care standards as identified during the Level I Assessment process. The LTSS Supports Coordinator must meet the following qualifications and conduct the following activities as appropriate:

The LTSS Supports Coordinator must meet the MDCH requirements for education and experience with the population.

The ICO will be responsible to provide, directly or contractually, the following LTSS Supports Coordination services:

- Support an on-going person-centered planning process
- Assist the enrollee to take a lead role in the process and provide information to the enrollee and ICT
- Contact and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment
- Participate in the assessment process as needed, including conducting the Level II Assessment specific to the enrollee's needs
- Participate on the enrollee's ICT
- Develop, with the enrollee and the ICT, an IICSP
- Ensure optimal utilization of information and community supports

- Arrange services as identified in the IICSP
  - Update the ICBR with current enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery
  - Monitor service implementation, service outcomes, and the enrollee's satisfaction
  - Collaborate with the ICO Care Coordinator to assist the enrollee during transitions between care settings, including full consideration of all options
  - Advocate for the enrollee and support self-advocacy by the enrollee
- vii. Responsibilities and Qualifications of PIHP Supports Coordinator: The PIHP network includes Supports Coordinators, Supports Coordinator Assistants, and Targeted Case Managers, which based on medical necessity and need, will be offered to enrollees with BH, SUD, and/or I/DD needs identified during the Level I Assessment process. For purposes of this document, the term "PIHP Supports Coordinator" refers to a qualified PIHP network provider of Supports Coordination or Targeted Case Management services.

The PIHP Supports Coordinator must meet qualifications and conduct the following activities as appropriate:

The PIHP will ensure that the PIHP Supports Coordinator meet the MDCH requirements for licensing, education, and experience

The PIHP Supports Coordinator will:

- Support the person-centered planning process
- Participate in the Level I Assessment when the enrollee has an identified BH, SUD, and/or I/DD need
- Complete a Level II Assessment of enrollees identified as having BH and/or I/DD service and support needs
- Develop, with the enrollee and the ICT, an IICSP
- Coordinate resources and authorize services (as permitted in the contracts between MDCH and the PIHP and between the ICO and PIHP)
- Coordinate psychiatric, psychopharmacological, rehabilitative, and habilitative services and supports in response to needs identified in the Level I Assessment, the Level II Assessment, and the IICSP
- Manage transitions among psychiatric acute and sub-acute levels of care and the community
- Ensure urgent and emergent care (including emergency department and/or inpatient diversion) due to exacerbation of BH, SUD,

and/or I/DD conditions (including crises secondary to medical or chronic illness)

- Coordinate and monitor in accordance with the IICSP activities for health-related behavioral conditions of enrollees with BH, SUD, and/or I/DD conditions
- Collaborate and consult with the ICO Care Coordinator regarding health, wellness, and preventive services for BH, SUD, and/or I/DD specialty populations
- Communicate, coordinate and monitor peer support/peer health navigator services, including enrollee engagement, health advocacy, and training in self-management of chronic illness
- Document in the ICBR and communicate with the enrollee and providers as needed

viii. Individual Integrated Care and Supports Plan (IICSP)

In consultation with the enrollee and the ICT, the ICO Care Coordinator will develop an Individual Integrated Care and Supports Plan (IICSP). This plan must focus on supporting the enrollee to achieve personally defined goals in the most integrated setting.

The IICSP will be developed through the person-centered planning process and will include the following essential elements:

- The enrollee's preferences for care, services, and supports
- The enrollee's prioritized list of concerns, goals and objectives, and strengths
- Specific providers, services and supports including amount, scope, and duration
- Results of the Initial Screening, Level I Assessment, and Level II Assessment (if performed)
- Summary of the enrollee's health status
- The plan for addressing concerns or goals and measures for achieving the goals
- The person(s) responsible for specific interventions, monitoring, and reassessment
- The due date for the interventions and reassessment

The IICSP will be completed for all enrollees within 90 calendar days of enrollment. Existing person-centered service plans or plans of care can be incorporated into the IICSP.

At the time of the Readiness Review, the ICO will submit to MDCH and CMS

policies and procedures that outline its implementation plan for the following:

- Development of the IICSP for each enrollee within 90 days of enrollment
- Defining the process for addressing the goals, services, and preferences identified by the enrollee in the IICSP
- Utilizing the ICT to develop a comprehensive plan reflecting the preferences of the individual across domains including physical, long term, and BH
- Ensuring the enrollee and his or her designee(s) and the ICT are working within the same IICSP and share responsibility for their contributions to the IICSP and supporting the enrollee in achieving his or her goals
- Incorporating the IICSP into the Integrated Care Bridge Record within 90 days of enrollment
- Making the IICSP available upon request to the enrollee in alternative formats and/or preferred written or spoken language
- Ensuring that the IICSP reflects assessment results, clinical data, BH, SUD, and I/DD utilization, and other pertinent information, as well as self and provider referrals

- ix. Person Centered Planning Process: Care coordination services for enrollees will be conducted using the person-centered planning process. The person-centered planning process actively engages the enrollee to identify strengths, capacities, preferences, needs and desired outcomes. The enrollee chooses the person to facilitate the person-centered planning process. The person-centered planning process should be conducted in person, unless desired otherwise by the enrollee.

The ICO will establish and submit policies and procedures that include:

- A process for person-centered planning that identifies the enrollee's preferences and choices regarding services and settings that is consistent with the MDCH definition
- A process for ensuring the provision of person-centered planning and treatment approaches are collaborative and responsive to the enrollee's changing and continuing needs
- A process for ensuring the participation of the enrollee and any family, friends, and professionals of his or her choosing, in discussions and decisions regarding treatments and services
- A process for ensuring that the enrollee receives all necessary information regarding treatment and service options to make informed choices

The ICO will participate in train-the-trainer person-centered planning

educational opportunities offered by MDCH. The ICO will be responsible for training ICO staff and network providers. The ICO will report participation in the MDCH and ICO trainings as required.

- x. **Self-Determination:** Self-Determination allows the opportunity for the enrollee to exercise choice and control in identifying, accessing, and managing services and supports in accordance with his or her needs and personal preferences. Arrangements that support Self-Determination enable enrollees to exercise authority over their LTSS by managing an individual budget for services and supports and/or directly employing and/or contracting with chosen providers.

The ICO will establish and submit policies and procedures to develop and implement mechanisms for enrollees to access arrangements that support Self-Determination consistent with MDCH requirements and guidance.

These policies and procedures will include provisions to:

- Inform the enrollee of his or her right to use arrangements that support Self-Determination and document the enrollee's decisions regarding these arrangements
  - Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination including the authority to control an individual budget (with the assistance of a fiscal intermediary) and the right to employ (hire, manage, and when necessary fire) workers and/or contract with providers
  - Make personnel available to help inform, navigate, connect, and refer the enrollee who are using arrangements that support Self-Determination
- xi. **Planning for Care Transitions:** The ICO will inform the enrollee of his or her right to live in the most integrated setting, inform the enrollee of the availability of services necessary to support his or her choices, and record the home and community-based options and settings considered by the enrollee.

The ICO will provide care coordination to facilitate timely and smooth transitions between care settings and between different providers of the same service. The ICO will ensure immediate and continuous discharge planning including electronic and verbal communication with the enrollee and ICT members following an enrollee's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, services and supports are in place in the community for the enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the enrollee has all necessary medications or prescriptions upon discharge, and conducting follow-up with the enrollee and/or caregiver.

At the time of the Readiness Review, the ICO will submit care transition policies and procedures that are subject to the approval of MDCH and CMS. These policies and procedures will be required in the contracts between the ICO and the regional PIHP.

- xii. Care Coordination Platform and Integrated Care Bridge Record (ICBR): The ICO will employ a Care Coordination platform, supported by web-based technology, that allows secure access to information and enables all enrollees and members of the Integrated Care Team to use and (where appropriate) update information. The ICO will be required to share information with PIHPs, across providers, and between ICOs through their Care Coordination platform. To minimize the duplicate data entry burden on providers that have already invested in certified electronic health records and who have or will soon achieve meaningful use stage one, two, or three compliance, the ICO will also support automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats. The platform will support the Integrated Care Bridge Record.

The Care Coordination platform will:

- Manage communication and information flow regarding referrals, care transitions, and care delivery
- Facilitate timely and thorough coordination and communication among the ICO, the primary care provider, PIHP and LTSS Supports Coordinators, and other providers
- Provide prior authorization information for services

The approved electronic platform will generate and maintain an individualized enrollee record referred to as the Integrated Care Bridge Record including:

- Current integrated condition list
- Contact information for Care Coordinator(s) and ICT Members
- Current medications list
- Dates of service and servicing providers for most recent provider and service contacts within PIHP and ICO systems
- Historical\* and Current Utilization and Claims information
- Assessments (Level I and Level II)
- Service outcomes, including specialty provider reports, lab results, and ER visits
- Individual Integrated Care and Support Plan (IICSP)

- Notes and correspondence functionality that allows care coordinators and providers to post key updates and notify ICT members.

The ICO will maintain the platform and address technological issues as they arise.

The ICO is responsible for initiating an ICBR for the enrollee and granting access to appropriate ICT members.

The ICO will provide ICBR in paper format to the enrollee upon request.

The ICO will verify the accuracy of the ICBR and amend or correct inaccuracies. Corrections or amendments must be dated and attributed to the person making the change.

The approved electronic platform will include a mechanism to alert ICT members of ED use or inpatient admissions.

The approved electronic platform will be HIPAA compliant and provide for the exchange of data in a standard format.

\* Historic Medicaid Utilization Data: MDCH will provide the ICO with access to a system to view historic utilization data. There will not be a direct exchange/interface from the MDCH system into the Integrated Care Bridge Record.

- b. Network Adequacy – State Medicaid standards shall be utilized for long-term supports and services, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

MDCH has developed transition requirements that specify continuation of existing providers for LTSS (see Table 7-C, “ICO Transition Requirements at Enrollment” below). MDCH and CMS also require that ICOs provide and arrange for timely access to all medically-necessary services covered by Medicare and Medicaid. Both MDCH and CMS will monitor access to services through survey, utilization, and complaints data to assess needs for ICO network corrective

actions. In addition to these protections, minimum LTSS standards for ICOs are below. Michigan will finalize the standards, based on administrative data and based on stakeholder input. CMS and MDCH will monitor access to care and the prevalence of needs indicated through enrollee assessments, and, based on those findings, may require that ICOs initiate further network expansion over the course of the Demonstration.

- The ICO is required to assure provider network adequacy and choice of providers. ICOs must have at least two available providers with sufficient capacity to accept enrollees, allowing enrollee choice of providers, including those providing supports coordination. When an ICO cannot assure choice within 30 miles for each enrollee, it may request a rural exception from MDCH.
- The ICO will directly employ or contract with independent care providers of the enrollee's choice, if the individual meets MDCH qualification requirements, to provide Medicaid Personal Care services. People who currently receive personal care services from an independent care provider may elect to continue to use that provider or select a new provider so long as that provider meets the state qualifications.

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

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. MDCH and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid beneficiaries, but will not do so in a manner that will dilute access to care for Medicare-Medicaid beneficiaries.

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

- c. Solvency—ICOs will be required to meet solvency requirements:
  - i. consistent with section 1903(m) of the Social Security Act, and regulations found at 42 C.F.R.. §422.402 and §438.116, and;

- ii. as specified in MDCH procurement, including rules developed by the Michigan Department of Insurance and Financial Services (DIFS). The DIFS is responsible for the licensing and monitoring of the financial solvency of health insuring corporations (HICs). All ICOs are required to have a Certificate of Authority to operate as a Health Maintenance Organization (HMO) in the State of Michigan in accordance with MCL 500.3505.
- d. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts -
  - i. ICOs must adhere to managed care standards at 42 C.F.R. §438.214 and 42 C.F.R. §422.204.

## **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 Michigan Medicaid) that are medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, the most cost-effective option in the least restrictive environment, and consistent with clinical standards of care. Medical necessity includes those services and supports designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.
  - 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 at least to the extent provided by Medicare and Michigan Medicaid as outlined in both state and federal rules. ICOs will be required to abide by the more generous of the applicable Medicare and Michigan Medicaid standards.
  - iv. The State will continue to contract directly with PIHPs for delivery of Medicaid behavioral health services. PIHP Coordinators will be responsible for ensuring the coordination of care of all Medicaid behavioral health services with other services as outlined in the IICSP.

- v. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.
  - vi. Amount, scope and duration of benefits will be determined through the assessment process.
- b. As a term and condition of this Demonstration, in addition to all Medicare Parts A, B, and D, and Medicaid State-plan services (except those covered through contracts between the State and the PIHPs), the ICOs will be required to provide services as defined in the approved 1915(b) and 1915(c) waivers. The 1915(c) services described in Table 7-A would be available to enrollees who meet NFLOC and for whom these services are included in the IICSP. The supplemental benefits described in Table 7-B would be provided to enrollees who meet established criteria and for whom the benefits are included in the IICSP.

**Table 7-A: Planned ICO Waiver Services**

<b>Waiver Service</b>	<b>Is this service currently available under the state plan?</b>
Adaptive Medical Equipment and Supplies	No
Adult Day Program	No
Assistive Technology	No
Chore Services	No
Expanded Community Living Supports	Yes. However, this service is beyond what is available via the state plan.
Community Transition Services	No
Environmental Modifications	No
Fiscal Intermediary (only under arrangements that support self-determination)	No
Home Delivered Meals	No
Non-Medical Transportation	No
Personal Emergency Response System	No
Preventive Nursing Services	No
Private Duty Nursing	Yes. However, this service is only available through the state plan for individuals under age 21.
Respite	No

**Table 7-B: Supplemental Benefits**

<b>Supplemental Benefits</b>	<b>Is this service currently available under the state plan?</b>
Adaptive Medical Equipment and Supplies	No
Community Transition Services	No
Fiscal Intermediary (only under arrangements that support self-determination)	No
Personal Emergency Response System	No
Respite	No

- c. Flexible Benefits – ICOs will have discretion to use the capitated payment to offer flexible benefits, as specified in the enrollee’s Individual Integrated Care and Supports Plan, as appropriate to address the enrollee’s needs.
- d. Services Provided through PIHPs – Behavioral Health Services including Substance Use, Intellectual Disability, and Development Disability services, as well as those behavioral health service traditionally covered by Medicare, will be provided through the local PIHP provider network. The State will continue to contract directly with PIHPs for delivery of Medicaid services, and payment through these contracts is not included in the payment to ICOs described in Appendix 6. The ICO will be required to contract with the regional PIHP for Medicare-funded behavioral health services, except when related to performance as specified in contracts between the ICOs and PIHPs for Medicare services. This does not include payment for medications as the ICO receives payment for Medicare Part D. Consistent with the prevailing Medicare benefits, Medicaid state plan, and Medicaid waiver authorities, the following behavioral health services will also be provided by the PIHPs for all enrollees with qualifying behavioral health needs:
- **Outpatient Visits (Medicaid and Medicare)** for enrollees with mild, moderate, or severe behavioral health needs;
  - **Other Medicaid Behavioral Health Services** (for enrollees with specialized needs related to the behavioral health and/or intellectual or developmental disability beyond covered acute care services)

- Assertive Community Treatment
- Assessments
- Assistive Technology
- Behavior Treatment Review
- Clubhouse Psychosocial Rehabilitation Programs
- Community Living Supports
- Crisis Interventions
- Crisis Observation Care
- Crisis Residential Services
- Enhanced Pharmacy
- Environmental Modifications
- Family Support and Training
- Family Therapy
- Fiscal Intermediary Services
- Health Services
- Home-based Services
- Housing Assistance
- Individual/Group Therapy
- Inpatient Psychiatric Hospital Admissions
- Intensive Crisis Stabilization Services
- Medication Administration
- Medication Review
- Nursing Facility Mental Health Monitoring
- Occupational Therapy
- Outpatient Partial Hospitalization Services
- Peer Delivered or Operated Support Services
- Personal Care in Licensed Specialized Residential Setting
- Physical Therapy
- Prevention Direct Service Model
- Respite Care Services
- Skill-Building Assistance
- Speech, Hearing, and Language
- Substance Abuse
- Support and Service Coordination
- Targeted Care Management
- Telemedicine
- Transportation
- Treatment Planning

The contract between the ICO and the PIHP must include mechanisms that will be used to establish collaborative processes for communication and integration of care through the Care Bridge, timeframes for sharing of information between PIHP and the ICO, and promote and assure shared responsibility for outcomes and quality improvement.

- e. Election of Medicare Hospice Benefit - If an enrollee elects to receive the Medicare hospice benefit, the enrollee will no longer be eligible for the demonstration. They will be disenrolled from the Demonstration and return to fee-for-service Medicare and Medicaid. The beneficiary will be required to select a Medicare Part D plan. A beneficiary who does not select a plan will be autoassigned, with LINet covering pharmacy services in the interim.
- f. Continuity of Care
  - i. ICOs must allow enrollees to maintain current providers and service levels at the time of enrollment as described in Table 7-C.
  - ii. ICOs are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract, single-case agreement, or out-of-network in order to meet the needs of the enrollee.
  - iii. Nursing facilities residents and waiver participants must continue to meet the NFLOC requirements to qualify for services.

**Table 7-C: ICO Transition Requirements at Enrollment**

<b>Transition Requirements<sup>3</sup></b>	<b>Habilitation Supports Waiver Enrollees and Enrollees Receiving Specialty Services and Supports Program through the PIHP</b>	<b>All Other Enrollees</b>
<b>Physician/Other Practitioners</b>	Maintain current provider at the time of enrollment for 180 days or continue with single case agreements. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner)	Maintain current provider at the time of enrollment for 90 days or continue with single case agreements. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner)
<b>DME</b>	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Same for all enrollees

<sup>3</sup>Requirements for all Medicare and Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.

<b>Scheduled Surgeries</b>	Must honor specified provider and PAs for surgeries scheduled within 180 days of enrollment	Same for all enrollees
<b>Chemotherapy/Radiation</b>	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Same for all enrollees
<b>Organ, Bone Marrow, Hematopoietic Stem Cell Transplant</b>	Must honor specified provider, PAs and plans of care	Same for all enrollees
<b>Dialysis Treatment</b>	Maintain current level of service and same provider at the time of enrollment for 180 days	Same for all enrollees
<b>Vision and Dental</b>	Must honor PAs when an item has not been delivered	Same for all enrollees
<b>Home Health</b>	Maintain current level of service and same provider at the time of enrollment for 180 days	Maintain current level of service and same provider at the time of enrollment for 90 days
<b>Medicaid Nursing Facility Services</b>	N/A	Enrollee may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the enrollee chooses to relocate.
<b>Waiver Services</b>	N/A – current providers and level of services will remain unchanged unless changed during the person-centered planning process.	N/A  *MI Choice HCBS waiver enrollees: Maintain current providers and level of services at the time of enrollment for 90 days unless changed during the person-centered planning process.

<p><b>State Plan Personal Care</b></p>	<p>Maintain current provider and level of services at the time of enrollment for 180 days. The IICSP must be reviewed and updated and providers secured within 180 days of enrollment.</p>	<p>Maintain current provider and level of services at the time of enrollment for 90 days. The IICSP must be reviewed and updated and providers secured within 90 days of enrollment.</p> <p>*Not applicable for MI Choice HCBS waiver enrollees</p>
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During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Enrollee requests a change;
- 2) The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid; or
- 3) The ICO, CMS, or MDCH identifies provider performance issues that affect an enrollee’s health and welfare.

g. **Out-of-Network Reimbursement Rules** – In an emergent or urgent situation, ICOs must reimburse an out-of-network provider of emergent or urgent care, as defined by 42 C.F.R. 424.101 and 42 C.F.R. 405.400 respectively, at the Medicare or Medicaid FFS payment amount applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. ICOs may authorize other out-of-network services to promote access to and continuity of care. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, the ICO will pay out-of-network providers at least the lesser of the providers’ charges or the Medicare FFS payment amount. When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, the ICO will pay out-of-network providers paid at established Medicaid fees in effect on the date of service. If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid policy for the determination of the correct payment amount.

h. **Nursing Facility Payment Rules** – Unless otherwise agreed to by the nursing facility and ICO, ICOs will be required to reimburse nursing facilities at the established Medicaid daily rate for days of services where Medicaid is the primary payer.

**VI. Model of Care-** All ICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components

consistent with the Special Needs Plan Model of Care. Michigan's comprehensive care coordination requirements summarized in Section IV will also apply and be outlined in the three-way contract. CMS' Demonstration plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

- (1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on the scoring methodology described in Appendix 2.
  
- (2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
  - Description of the Plan-specific Target Population;
  - Measurable Goals;
  - Staff Structure and Care Management Goals;
  - Interdisciplinary Care Team;
  - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
  - MOC Training for Personnel and Provider Network;
  - Health Risk Assessment;
  - Individualized Care Plan;
  - Integrated Communication Network;
  - Care Management for the Most Vulnerable Subpopulations; and
  - Performance and Health Outcomes Measurement.
  
- (3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration plan application. The factors for each element will be scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is CMS' intent for MOC reviews and approvals to be a multi-year process that will allow Demonstration plans to be granted up to a three-year approval of their MOC based on higher

MOC scores above the passing standard. The specific time periods for approvals are as follows:

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

ICOs will be permitted to cure problems with their MOC submissions after their initial submissions. ICOs with MOCs scoring below 70 percent will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, ICOs with MOCs that do not meet CMS' standards for approval will not be eligible for selection as Demonstration plans.

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

**VIII. Grievances** – Enrollees and their authorized representatives shall be entitled to file internal grievances directly with the ICO and PIHP. Each ICO and PIHP 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. The ICO shall inform enrollees that they may also file an external Grievance through 1-800 Medicare.

**IX. Appeals** – Other than Medicare Part D appeals, which shall remain unchanged, the following is the approach for an integrated Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

- i. Integrated Notice - ICO 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 MDCH and CMS. PIHPs will also use this integrated notice and forms, but their other processes will remain the same.

- ii. Appeal time frames - Time frames for filing an appeal related to benefits will be unified.
  - 1. For services for which Medicare is the primary payer, Enrollees, their authorized representatives and providers will have 90 days from date of notice of the action to file an appeal related to denial or reduction or termination of authorized Medicare benefit coverage. For Medicare service appeals that have been inappropriately made to the Department of Licensing and Regulatory Affairs through the Michigan Administrative Hearing System (MAHS) for MDCH instead of the plan ICOs will be directed in the three-way contract to follow applicable time frames,. Such appeals will be forwarded by MAHS to the applicable ICO for a determination.
  - 2. Individuals or their authorized representatives will have 90 days from date of notice of the action to file an appeal related to denial, suspension, reduction or termination of authorized Medicaid benefits.
- iii. Appeal levels - Enrollees will continue to have full access to the Medicare and Medicaid appeals process for benefit appeals pursuant to title XVIII and section 1902(a)(3) of the Social Security Act and implemented at 42 C.F.R. 431.10. Initial appeals for Medicare service denials, reductions and terminations will be made to the ICOs; sustained decisions will be auto-forwarded to the Medicare Independent Review Entity (IRE). Enrollees will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE. Initial appeals for Medicaid service denials will be made to the ICO and/or MAHS. Sustained ICO decisions resulting in Medicaid service denials will not be auto-forwarded to MAHS, but may be appealed by enrollees or their authorized representative to MAHS. For services that may be eligible for both Medicare and Medicaid coverage, individuals may file an appeal through either the Medicaid or Medicare appeals processes or both. CMS and Michigan will continue to work to further integrate the appeals process over the course of this demonstration.
- iv. Appeal resolution time frames – The ICO shall resolve appeals consistent with 42 C.F.R. § 422.560 et seq. and 42 C.F.R. § 438.408. For requests for services, all appeals must be resolved by the ICO as expeditiously as

the enrollee condition requires, but within 30 calendar days of request for standard appeals, and within 72 hours of request for expedited appeals. MAHS will resolve appeals as expeditiously as the enrollee condition requires consistent with 42 C.F.R. § 431.244(f). An extension of the timeframe may only apply when such extension is consistent with 42 C.F.R. § 438.408(c)(1)(ii): Note: The plan may extend the timeframes from this section by up to 14 calendar days if the enrollee requests the extension, or if the 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.

- v. Continuation of Benefits Pending Appeal - Continuation of all non-part D benefits will be required to be provided pending internal ICO appeals, provided the appeal is requested to the ICO within the latter of applicable timeframes for making such request or the effective date of the proposed action. As provided in 42 C.F.R §§ 431.211 and 230 and 438.420, continuations of covered Medicaid services will continue to be required when a request is made to MAHS within the applicable timeframes for making such request. This means that authorized benefits will continue to be provided by providers to enrollees, and that ICO must continue to pay providers for providing services pending an internal ICO appeal or state 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.
- vi. In the case of a decision where both MAHS and the IRE issue a ruling, the ICO shall be bound by the ruling that is most favorable to the enrollee.

## **X. ICO Marketing, Outreach, and Education Activity**

- a. 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 MDCH do not need to be reviewed or submitted in HPMS. However, CMS and MDCH agree to work together in the development of these materials.

- b. Marketing and Enrollee Communication Standards for ICOs – ICOs 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 C.F.R. §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. ICOs will not be allowed to market directly to potential ICO enrollees on a one-on-one basis but may provide responses to enrollee-initiated requests for information and/or enrollment. ICOs may participate in group marketing events and provide general audience materials (such as general circulation brochures, and media and billboard advertisements). ICOs must refer all potential enrollees to the State or its vendor for enrollment. CMS and MDCH will develop a process to mitigate beneficiary shifting from ICOs to other plans operated by the same parent company. At a minimum, the three-way contract will identify procedures to provide additional education to enrollees that are considering opting out of an ICO for a non-ICO that may be a part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and MDCH.
- c. Review and Approval of Marketing and Enrollee Communications – ICOs must receive prior approval of all marketing and enrollee communications materials in categories of materials that CMS or MDCH requires to be prospectively reviewed. ICO materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and MDCH. CMS and MDCH 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. ICOs must submit all marketing and enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
- d. Permissible Start Date for ICO Marketing Activity – ICOs may begin marketing activity, as limited by paragraph (i) above, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- e. CMS and Michigan will work together to educate beneficiaries about their ICO options. MDCH’s independent enrollment broker will be responsible for

educating enrollees on all potential plan choices through a variety of mechanisms. Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, limited English proficiency, and low functional literacy.

- f. Michigan will use the services of the State Health Insurance Program, MMAP, in conjunction with the Enrollment Broker to provide outreach and enrollment options counseling for potential enrollees. Services are provided via telephone and in person, either individually or in groups.
- g. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, ICOs 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 C.F.R. §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 additional benefits, in addition to the required Medicare benefits information. Additional content will be required by MDCH., e.g. notice of privacy practices; eligibility requirements for Demonstration enrollment; excluded services; enrollee rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the ICO ID card replaces the Medicare and Medicaid cards; the enrollee’s requirement to select a PCP and how to change PCP; out of network policies; the availability of 911 services; the right to change plans and the procedure for requesting a change; appeal, grievance and state hearing rights and required standard and expedited resolution timeframes; non-discrimination requirements; information on enrollees’ right to execute advance directives; how to contact the Department of Community Health with concerns about the ICO; the structure and operation of any physician incentive plans the ICO may have in place; how to access additional information in alternative formats or languages; how to access the ICO provider and pharmacy directory; the name of the ICO’s parent company and any DBA that may be used; toll-free enrollee services and care management and nurse advice

24-hour service lines; and any other content required by state or federal regulation.

- ii. An Annual Notice of Change (ANOC) summarizing all major changes to the plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
  - iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. The Summary of Benefits must contain language that instructs enrollees how and where to obtain services for BH, SUD, and I/DD through the PIHP. ICOs will use a Demonstration-specific Summary of Benefits.
  - iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
  - v. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the ICO.
  - vi. A single identification (ID) card for accessing all covered services under the ICO.
  - vii. All Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.
- f. Notification of Formulary Changes – The requirement at 42 C.F.R. §423.120(b)(5) that ICOs provide at least 60 days advance notice regarding Part D formulary changes also applies to ICOs for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

## **XI. Administration and Oversight**

- a. Oversight Framework
  - i. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity,

compliance with applicable laws, including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and MDCH will require ICOs to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. ICOs 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 benefits, including prescription drugs, medical care, and long term services and supports. In addition, all Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to ICOs by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.

These responsibilities are not meant to detract from or weaken any current 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 MDCH, authorized and empowered to represent CMS and MDCH about aspects of the three-way contract. Generally, the CMS members of the team will include MDCH Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term supports and services.
- ii. Reporting – Data reporting to CMS and MDCH will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the three-way contract.

1. Quality (including HEDIS); core measures will be articulated in Section H below.
2. Rebalancing between Institutional and HCBS Settings
3. Utilization
4. Encounter Reporting
5. Enrollee Satisfaction (including CAHPS)
6. Complaints and Appeals
7. Enrollment/ Disenrollment Rates
8. Part C and Part D Reporting Requirements, as applicable
9. All required 1915(b) and (c) waiver reporting

c. Day-to-Day Oversight and Coordination

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

- Monitoring compliance with reporting requirements;
- Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
- Coordination of periodic audits and surveys of the ICO;
- Receipt and response to complaints;
- Review reports from and responses to the Ombudsman;
- Reviewing direct stakeholder input on both plan-specific and systematic performance;
- Participating in regular meetings with each ICO;
- Coordinating requests for assistance from contractors, and assignment of appropriate State and CMS staff to provide technical assistance;

- Coordinating review of marketing materials and procedures; and
- Coordinating review of grievance and appeals data, procedures, and materials.

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

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. Demonstration contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The 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 MDCH 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 MDCH 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. ICO Call Center Requirements

ICOs 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 and Demonstration specific requirements:

- ICOs shall operate a toll-free enrollee services telephone line for administrative purposes, consistent with Marketing Guidance. The line will be available nationwide for a minimum of 8am to 8pm Eastern Time, seven days a week. A toll-free TTY number or state

relay service must be provided, as long as the number included is accessible from TTY equipment.

- To support care coordination, ICOs shall operate a twenty-four hour, seven-days-a-week, toll free call in system available nationwide that is staffed by appropriately trained and qualified health professionals who, according to HIPAA laws, assess the enrollee's issues and provide an appropriate course of action (i.e., medical advice, direct the enrollee to an appropriate care setting, etc.). The ICO must ensure that if care management needs are identified for an enrollee that the ICO staff person facilitating the enrollee's issue has access to, and is familiar with, the enrollee's plan of care. ICOs must ensure that follow-up is timely and appropriate to assure the enrollee's health and welfare.
- Operators must be available in sufficient numbers to support current and prospective enrollees and meet CMS and Michigan specified standards.
- ICOs shall have interpreter service 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.
- Plans must ensure that customer service representatives shall, upon request, make available to enrollees and potential enrollees information including, but not limited to, the following:
  - The identity, locations, qualifications, and availability of providers;
  - Enrollees' rights and responsibilities;
  - The procedures available to an enrollee and/or provider(s) to challenge or appeal the failure of the contractor to provide requested coverage and to appeal any adverse actions (denials);

- Process by which an enrollee may access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
  - Process by which an enrollee can access the Demonstration’s Ombudsman, the MDCH Beneficiary Call Center and 1-800-Medicare;
  - Information on all ICO covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
  - The procedures for an enrollee to change plans or to opt out of the Demonstration.
- g. Data System Specifications, Reporting Requirements, and Interoperability. To the maximum extent possible, CMS and MDCH 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, State of Michigan Providers and Contractors, and Health Insurance Marketplaces
- h. Unified Quality Metrics and Reporting

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

MDCH will supplement quality reporting requirements with additional State-specific measures. MDCH will also be required to report on long term supports and services as delineated in approved waivers and will coordinate the quality requirements as feasible. ICOs must collaborate with PIHPs to obtain data for the reporting of services provided through the PIHPs. Details will be included in the contract between the ICO and PIHP.

A combined set of core metrics is described below in Table 7-C; more detail on the measures will be provided in the three-way contract. CMS and MDCH 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 (denoted by the \*). This subset consists of a combination of national and State-specific metrics appropriate for Michigan’s Demonstration population, including measures for acute care, nursing facility care, and rebalancing and diversion from nursing facilities. ICOs must submit data consistent with requirements established by CMS and/or the State as further described below and in the three-way contract. ICOs 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-C: Core Quality Measures under the Demonstration**

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Antidepressant Medication Management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	x

Initiation and engagement of alcohol and other drug dependence treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS	X	x
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	x*	x*
Screening for clinical depression and follow-up care	Percentage of members ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	x*	x*

<p>SNP 1: Complex Case Management</p>	<p>The organization coordinates services for members with complex conditions and helps them access needed resources.  Element A: Identifying Members for Case Management  Element B: Access to Case Management  Element C: Case Management Systems  Element D: Frequency of Member Identification  Element E: Providing Members with Information  Element F: Case Management Assessment Process  Element G: Individualized Care Plan  Element H: Informing and Educating Practitioners  Element I: Satisfaction with Case Management  Element J: Analyzing Effectiveness/Identifying Opportunities  Element K: Implementing Interventions and Follow-up Evaluation</p>	<p>NCQA/ SNP Structure &amp; 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 members.  Element A: Coordination of Benefits for Dual Eligible Members  Element B: Administrative Coordination of D-SNPs  Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos)  Element D: Service Coordination  Element E: Network Adequacy Assessment</p>	<p>NCQA/ SNP Structure &amp; Process Measures</p>	<p>X</p>	

Care Transition Record Transmitted to Health Care Professional	Percent of Demonstration members 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 to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	x*	
Medication Reconciliation After Discharge from Inpatient Facility	Percent of members 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 Members 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	

<p>CAHPS (or other Surveys), various settings including:</p> <ul style="list-style-type: none"> <li>- Health Plan plus supplemental items/questions, including:</li> <li>- Experience of Care and Health Outcomes for Behavioral Health (ECHO)</li> <li>- Home Health</li> <li>- Nursing Home</li> <li>- People with Mobility Impairments</li> <li>- Cultural Competence</li> <li>- Patient Centered Medical Home</li> </ul>	<p>Depends on Survey</p>	<p>AHRQ/CAHPS</p>	<p>X</p>	<p>x</p>
<p>Part D Call Center – Pharmacy Hold Time</p>	<p>How long pharmacists wait on hold when they call the drug plan’s pharmacy help desk.</p>	<p>CMS Call Center data</p>	<p>X</p>	
<p>Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability</p>	<p>Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan’s customer service phone number.</p>	<p>CMS Call Center data</p>	<p>X</p>	
<p>Part D Appeals Auto-Forward</p>	<p>How often the drug plan did not meet Medicare’s deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as:  <math display="block">\left[ \frac{\text{Total number of cases auto-forwarded to the IRE}}{\text{Average Medicare Part D enrollment}} \right] * 10,000.</math></p>	<p>IRE</p>	<p>X</p>	

Part D Appeals Upheld	<p>How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member'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 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 Enrollee Access and Performance Problems	<p>To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems</p>	CMS Administrative data	X	
Part D Members Choosing to Leave the Plan	<p>The percent of drug plan members who chose to leave the plan in 2013.</p>	CMS Medicare Beneficiary Database Suite of Systems	X	

Part D Medicare Plan Finder (MPF) Accuracy	The accuracy of how the Plan Finder data match the Prescription Drug Event data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	
Part D Diabetes Treatment	Percentage of Medicare Part D enrollees who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	x*	
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	

Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Governance board	Establishment of enrollee advisory board or inclusion of enrollees 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. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	x*	
Assessments	Percent of enrollees with initial assessments completed within specified timeframe.	CMS/State defined process measure	x*	x*
Individualized Care Plans	Percent of enrollees with care plans by specified timeframe.	CMS/State defined process measure	X	
Real time hospital admission notifications	Percentage of hospital admission notifications occurring within specified timeframe	CMS/State defined process measure	X	
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators	CMS/State defined process measure	X	
Discharge follow up	Percentage of enrollees with 30 days between hospital discharge to first follow-up visit	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS/State defined process measure	X	
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	x*	

Care for Older Adults – Functional Status Assessment	Percent of plan members who have received a functional status assessment to see how well they are doing activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X	
Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X	
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X	
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X	
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	x*	
Plan all-cause readmissions	Percent of member discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	x*	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	x*	x

Comprehensive medication review	Percentage of members who received a comprehensive medication review (CMR) by population.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	x
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM)/(Average Contract enrollment)] * 1,000 * 30 / Number of Days in Period).	CMS CTM data	X	
Enrollee Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan per CMS timeframe.	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 members to get information from their drug plan about prescription drug coverage and cost.</p> <p>-In the last 6 months, how often did your health plan’s customer service give you the information or help you needed about prescription drugs?</p> <p>-In the last 6 months, how often did your plan’s customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?</p> <p>-In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered?</p> <p>-In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?</p>	AHRQ/CAHPS	X	
Rating of Drug Plan	<p>The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?</p>	AHRQ/CAHPS	X	

Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	x*	

Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. Using any number from 0 to 10, where 0 is the worst 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	Percent of best possible score the plan earned from plan members who rated the overall plan. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	x*	
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	

Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	
Tracking of demographic information	Percent of all Demonstration enrollees for whom specific demographic data is collected and maintained in the Integrated Care Bridge Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure		x
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure	x*	
Access to an LTSS and PIHP Supports Coordinator	Percent of enrollees with LTSS needs who have an LTSS Supports Coordinator and Percent of enrollees with Behavioral health needs who have a PIHP Supports Coordinator unless they opt out.	CMS/State defined process measure		x
Ensuring physical access to buildings, services and equipment	ICO has established a work plan to meet ADA standards and accommodate people and there is an identified individual in its organization who is responsible for ADA compliance related to this Demonstration.	CMS/State defined process measure	X	x
Documented Discussion of Member Rights and Member Choices for Providers	Percent of enrollees with documented discussion of their rights and choices for providers.	CMS/State defined process measure		x

Population based quality of life survey	Population based quality of life survey	CMS/State defined process measure		x
Residents experiencing one or more falls with a major injury	Percent of residents experiencing one or more falls with a major injury	NQF/CMS		x
Urinary Tract Infection	Percent of enrollees (specified population) with urinary tract infections.	CMS/State defined process measure		x*
Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90)		AHRQ/PQI		x
Emergency Department Visits for Ambulatory Care-Sensitive Conditions (Rosenthal)	Primary Care Sensitive ED Visits per 1000 members for non-emergent; emergent, but primary care treatable; emergent, ED care needed but preventable/avoidable; and emergent, ED care needed, not preventable/avoidable.	AHRQ/PQI		x
The ICO, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	The number of abuse, neglect and exploitations that meet state adult protective services definitions that are reported, investigated and addressed	CMS/State defined process measure		x
New members starting any needed on-going service within 14 days of a non-emergent assessment	The percent of new enrollees starting any needed on-going service within 14 days of completion of the initial care and supports plan for non-emergency new members with non-emergent needs.	CMS/State defined process measure		x
Self-management support	Measurement consistent with primary care medical home self-management support recommendation	CMS/State defined process measure		x
Satisfaction with information, care coordination and access to records	Percent of enrollees who report that they were satisfied with information, care coordination and access to care records	CMS/State defined process measure		x

Demonstrated use of person centered planning using defined DCH person centered planning principles	Number of all enrollees with person-centered plans reported to be developed in accordance with person centered planning principles.	CMS/State defined process measure		x
Care for persons with I/DD –Assessment	Percent of enrollees with I/DD who have a completed assessment and related goals in the care plan	CMS/State defined process measure		x
Care for persons with Mental Illness – Assessment	Percent of enrollees with Mental Illness who have a completed assessment and related goals in the care plan	CMS/State defined process measure		x
Community and social connectedness	Percent of enrollees satisfied with involvement natural supports and community	CMS/State defined process measure		x
Self - determination	Establishment of a baseline and then rate of increase for enrollees using self-directed arrangements	CMS/State defined process measure		x
Complex care needs	Percent of providers who provide prompt and timely interventions to persons identified with complex care needs.	CMS/State defined process measure		x
Antipsychotic & Bipolar Medication Management	Percent of persons diagnosed, prescribed medications, and chose to remain with their regimen.	CMS/State defined process measure		x
Disenrollment	The total number of voluntary disenrollment requests received in the specified time period.	CMS/State defined process measure		x
Adult Body Mass Index (BMI) Assessment	Percentage of enrollees 18 to 64 years of age who had an outpatient visit and whose BMI was documented.	NCQA/HEDIS		
Nursing Facility Diversion Measure	Reporting of the number of enrollees who lived outside the nursing facility during the current measurement year as a proportion of the enrollees who lived outside the nursing facility during the previous year.	CMS/State defined process measure		x
Annual Dentist Visit	Percentage of enrollees who had at least one dental visit during the measurement year.	NCQA/HEDIS		x

\*Asterisks denote withhold measures specified in *Appendix 6: Payments to ICOs*

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

## **XII. Stakeholder Engagement**

MDCH will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through regional Open Forums, an Advisory Committee, and monitoring of individual and provider experiences through a variety of means, including surveys, website updates, and data analysis. In addition, as described in Section III.C.10 of the MOU, MDCH will require that ICOs develop meaningful enrollee input processes (including representation of enrollees on ICO advisory boards) as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to enrollees. MDCH will also develop enrollee notices and related materials about the Demonstration program that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by CMS and MDCH.

## **XIII. Evaluation**

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the Financial Alignment models, including this Demonstration, on enrollee experience of care, quality, utilization, and cost. The evaluator will also explore how the 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, including use of home and community-based LTSS and institutional LTSS;
- Enrollee satisfaction and experience;

- Administrative and systems changes and efficiencies; and
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for the Michigan Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. In addition to the topics above, the Michigan evaluation will focus on issues associated with the PIHP and Care Bridge arrangements, including to beneficiary experiences, administrative issues, cost shifting, and access to care, especially for mental health services, treatment for substance use disorders, and other services coordinated through the PIHPs. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected quality utilization, and cost measures over the course of the Demonstration; evaluating the impact of the Demonstration on quality, utilization, and cost measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. Quarterly reports provided to CMS and MDCH will include rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Michigan-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

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

MDCH 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. MDCH 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)
  - Nursing facility status – Coded 1 if residing in nursing facility, and zero if not
  - HCBS waiver status – Coded 1 if enrolled in an HCBS waiver, and zero if not
  - 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 MDCH Data Reporting System, including but not limited to:
    - The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g. individuals residing in ICF/IDs or State mental hospitals; HCBS waiver, PACE, and Money Follows the Person enrollees, etc.)
    - The number of beneficiaries enrolled in the Demonstration
    - The number of beneficiaries who opt out of the Demonstration
    - The number of beneficiaries who disenroll from the Demonstration
    - The number of plans participating in the Demonstration

MDCH will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Demonstration enrollee. MDCH will also have the capability to track enrollee-level data on grievances, and appeals that identify the health plan and providers involved.