Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Wisconsin

Regarding A Federal-State Partnership to Test a Capitated Integration Model for Medicare-Medicaid Enrollees

Demonstration to Integrate Care for Dual Eligible Beneficiaries

This is Wisconsin's proposed MOU draft. It was originally based on a CMS template, but includes numerous edits and updates proposed by Wisconsin.

This state drafted version reflects the design proposal of Wisconsin's Integrated Demonstration, with updates from versions previously submitted to CMS and posted on the Department of Health Services website. This draft was submitted to CMS 8/12/13.

Table of Contents

I. STATEMENT OF INITIATIVE 1

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING 3

III. PROGRAM DESIGN / OPERATIONAL PLAN 4

A. PROGRAM AUTHORITY 4

B. CONTRACTING PROCESS 5

C. ENROLLMENT 7

D. DELIVERY SYSTEMS AND BENEFITS 10

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE 11

F. INTEGRATED APPEALS AND GRIEVANCES 15

G. ADMINISTRATION AND REPORTING 16

H. QUALITY MANAGEMENT 19

I. FINANCING AND PAYMENT 19

J. EVALUATION 20

K. EXTENSION OF AGREEMENT 21

L. MODIFICATION OR TERMINATION OF AGREEMENT 21

M. SIGNATURES 24

Appendix 1: Definitions 25

Appendix 2: CMS Standards and Conditions and Supporting State Documentation 30

Appendix 3: Details of State Demonstration Area 37

Appendix 4: Medicare Authorities and Waivers 38

Appendix 5: Medicaid Authorities and Waivers 40

Appendix 6: Payments to Participating Plans 42

Appendix 7: Demonstration Parameters 57

I. State of Wisconsin Delegation of Administrative Authority and Operational Roles and Responsibilities 57

II. Plan or Qualified Entity Selection 57

III. State Level Enrollment Operations Requirements 58

IV. State Level Delivery System Requirements 60

V. Benefits 67

VI. Model of Care 71

VII. Prescription Drugs 73

VIII. Grievances 74

IX. Appeals 74

X. Participating Plan Marketing, Outreach, and Education Activity 77
XI. Administration and Oversight 83
XII. Evaluation 98

I. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Wisconsin (State/State) to implement the Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration) to better serve individuals eligible for both Medicare and Medicaid ("Medicare-Medicaid Enrollees" or "dual eligibles"). The Federal-State partnership will include a three-way contract with Participating Plans ("Participating Plans") that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s). The Demonstration will begin on January 1, 2014 and continue until December 31, 2016, unless terminated pursuant to section L or continued pursuant to section K of this Memorandum of Understanding (MOU).[1] The initiative is intended to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

Individuals ages 21 and older at the time of enrollment who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and any full-benefit Wisconsin Medicaid benefit plan and whose stay in a participating nursing home is funded by Medicaid will be eligible for enrollment in this initiative, as discussed in more detail in section C.1 below.

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

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

[1] Dates may be revised once timelines are known.

Key objectives of the initiative are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid and achieve cost savings for the State and Federal government through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and the State expect Integrated Care Organization (ICO) and provider implementation of the independent living and recovery philosophy, wellness principles, and cultural competence to contribute to achieving these goals.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations; the demonstration targets an institutional population, but also includes providing care for eligible beneficiaries who may relocate to the community. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU or other Wisconsin waivers, Participating Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, as will be further specified in a three-way contract to be executed among the Participating Plans, the State, and CMS.

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

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary safeguards and will be included in this MOU and the three-way contract. Participating Plans will have full accountability for managing the integrated blended capitated payment to best meet the needs of Enrollees according to Individualized Care Plans developed using a person-centered planning process. CMS and the State expect Participating Plans to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, Participating Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost traditional services if indicated by the Enrollees' wishes, needs and Individualized Care Plan.

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

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the principles under which CMS and the State plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with Participating Plans setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about Participating Plan responsibilities will be included in and appended to the three-way contract.

The State has released a Phase One Certification Document and will continue to issue additional certification requirements in a phased process ending with Readiness Reviews. Following the signing of this MOU and prior to the implementation of the Demonstration, CMS and State will ultimately enter into three-way contracts with selected plans, which will have also met the

Medicare components of the Plans selection process, including submission of a successful Medicare Part D application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. These three-way contracts will include the additional operational and technical requirements pertinent to the implementation of the Demonstration.

III. PROGRAM DESIGN / OPERATIONAL PLAN

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

A. PROGRAM AUTHORITY

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, Participating Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 C.F.R. Parts 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the three-way contract.

2. **Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, Participating Plans will be required to comply with Medicaid managed care

requirements under Title XIX and 42 C.F.R. §438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the three-way contract.

B. CONTRACTING PROCESS

1. **Participating Plan Certification Documents:** The State has begun a phased certification process that, consistent with applicable State law and regulations, includes purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. Participating Plans are also required to meet the Medicare components of the plan selection process incorporated into the integrated certification process. The integrated certification process will be utilized to select entities that will be eligible to contract with CMS and the State.

   All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements will be cited in the certification documents.

2. **Participating Plan Certification:** CMS and the State shall contract with qualified Participating Plans meeting certification criteria. See Appendix 7 for more information on the plan selection process.

3. **Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section 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 waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Act, afford the State an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

5. **Readiness Review:** CMS and the State, either directly or with contractor support, shall conduct a readiness review of each selected Participating Plan. Following the signing of the three-way contract, CMS and the State must agree that a Participating Plan has passed readiness prior to that Plan accepting any enrollment. CMS and the State will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential Participating Plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.

6. **Three-way Contract:** CMS and the State shall develop a single three-way contract and contract negotiation process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations:

- Individuals in the State age 21 or older at the time of enrollment who reside in a nursing home and meet the specific criteria below who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and Medicaid will be eligible for enrollment in this initiative. This includes individuals with End Stage Renal Disease (ESRD) at the time of enrollment.
- Specific nursing home resident criteria:
    - The individual must reside in a participating nursing home to become eligible for the demonstration. A participating nursing home is defined as a nursing home that has chosen to sign a contract with a Participating Plan to participate in the demonstration.
    - The individual's nursing home stay at the time of enrollment must be paid only by Medicaid; there must be no Medicare payment for the nursing home care at the time the individual is enrolled. Individuals residing in a nursing home on a Medicare paid post-acute stay are not eligible to enroll in the demonstration at that time. Once an individual has enrolled, eligibility is retained through subsequent hospitalizations and Medicare-paid nursing home stays.
- Individuals residing in an ICF/MR facility may not enroll or be enrolled in this Demonstration.

- Beneficiaries enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), any State Medicaid or Long Term Care managed care program such as Family Care (FC), Family Care – Partnership (FCP), or SSI Managed Care, any State home and community based services (HCBS) waiver program such as IRIS, CIP/COP, or Children's waivers, Employer Group Waiver Plans (EGWP) or other Employer-Sponsored Plans, or plans receiving a Retiree Drug Subsidy (RDS), or any other supplemental or comprehensive insurance coverage, and who meet the eligibility criteria for this Demonstration, may opt-in to participate in this initiative, but will not be passively enrolled. Individuals enrolled in any current managed care program may opt-in only if they choose to disenroll from their existing programs.
- Individuals who enroll in the Demonstration while residing in a participating nursing home and subsequently relocate to a community setting will remain eligible for and retain enrollment in the Demonstration unless they choose to disenroll or become ineligible for Medicaid or Medicare. The Long Term Care Functional Screen (LTCFS) will be used to establish the nursing home level of care (NH LOC) eligibility for HCBS in the community. Individuals whose level of care decreases from NH LOC to non-NH LOC will remain enrolled and receive benefits as described in Appendix 7 Section V.
- To best ensure continuity of beneficiary care and provider relationships, CMS will work with the State to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be attributed to an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

2. **Enrollment and Disenrollment Processes:** Enrollment into a Participating Plan may be conducted using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively

enrolled will have the opportunity to opt-out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7. Disenrollment from Participating Plans and transfers between Participating Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing laws, for the purposes of identifying any inappropriate or illegal marketing practices. 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 the State will utilize the Medicaid fiscal agent or another independent third party entity to facilitate all enrollment into the Participating Plans. Participating Plan enrollments and disenrollments shall become effective on the same day for both Medicare and Medicaid (the first of the month), except that when a beneficiary dies, disenrollment shall be effective on the date of death. For those who lose Medicaid eligibility during the month, except for when the beneficiary dies, coverage and Federal financial participation will continue through the end of that month.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.

4. **Outreach and Education:** Participating Plan outreach and marketing materials will be subject to a single set of marketing rules by CMS and the State, as further detailed in Appendix 7.

5. **Single Identification Card:** CMS and the State shall work with Participating Plans to develop a single identification card that will be used to access all care needs, as further detailed in Appendix 7.

D. DELIVERY SYSTEMS AND BENEFITS

1. **Participating Plan Service Capacity:** CMS and the State shall contract with Participating Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees, in accordance with this MOU, CMS guidance, and the three-way contract. Medicare covered benefits shall be provided in accordance with 42 CFR 422 and 42 CFR 423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, the -waivers in Appendix 4 and Appendix 5, and in accordance with the requirements specified in the State certification documents and this MOU. In accordance with the three-way contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering supplemental benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and Participating Plans will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and supportive service providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. **Participating Plan Risk Arrangements:** CMS and the State shall require each Participating Plan to provide a detailed description of its risk arrangements with providers under subcontract with the Participating Plan. This description shall be made available to Plan Enrollees upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to Enrollees.

3. **Participating Plan Financial Solvency Arrangements:** CMS and the State have established a standard for all Participating Plans, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. **Choice of Plans and Providers:** As referenced in section C.2, Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different Demonstration Plan, a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State's approved State Plan and any approved waiver programs.

2. **Continuity of Care:** CMS and the State will require Participating Plans to ensure that individuals continue to have access to medically necessary items, services, and medical and long-term service and support providers for the transition period as specified in Appendix 7. In addition, Participating Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.

3. **Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, Medicaid-Medicare beneficiaries will be provided with enrollment assistance from a Helpline operated by either the Medicaid fiscal agent or another independent entity to help them make an enrollment decision that best meets their needs. Options counseling will remain available from Aging and Disability Resource Centers.

4. **Ombudsman:** The Wisconsin Board on Aging and Long Term Care (BOALTC), through its Long-term Care Ombudsman Program, is statutorily authorized within Wisconsin (§ 16.009, WI stat.) to investigate complaints and advocate on behalf of people who are aged 60 or over, including individuals who are enrolled in Family Care program, recipients of services funded through the state's Community Options Program, and long term care facility residents.

Ombudsmen provide direct consumer assistance and advocacy, safeguard due process, and serve as an early and consistent means of identifying systemic problems. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS and the State will provide ongoing technical assistance to the Ombudsman

BOALTC will provide ombudsman services to individuals eligible for participation in Wisconsin's integrated demonstration, to include advocacy and monitoring efforts on compliance with principles of community integration, independent living, person-centered care, and integrated CMS and DHS care systems across the institutional and the home and community-based care settings. This will include gathering and reporting data specific to the Demonstration to the State and to CMS via the contract management team described in Appendix 7 of this MOU.

5. **Person-Centered**, **Appropriate Care:** CMS, the State, and Participating Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the beneficiary's functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers, and are in a care setting appropriate to their needs, with a preference for the home and the community for those beneficiaries who are able to and choose to relocate to the community. CMS, the State, and Participating Plans shall ensure that care is person-centered and can accommodate and support self-direction. Participating Plans shall also ensure that medically necessary covered services are provided to beneficiaries, in the least restrictive setting, and in accordance with the Enrollee's wishes and Individualized Care Plan.

6. **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and the State expect Plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the ICO model and will support better health outcomes for ICO Enrollees. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. The State and CMS will require ICOs to contract with providers that

demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. The State and CMS also recognize that access includes effective communication. The State and CMS will require 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 and accommodations for members with cognitive limitations, and interpretation for persons with limited English proficiency. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, and wellness philosophies. CMS and the State will continue to work with stakeholders, including Demonstration participants, 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 the State are committed to compliance with the ADA, including application of the Supreme Court's Olmstead decision, and agree to ensure that ICOs provide for Demonstration Enrollees long-term services and supports in care settings appropriate to their needs.

7. **Enrollee Communications:** CMS and the State agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the Participating Plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard

providing the greatest access to individuals with disabilities or limited English proficiency will apply.

8. **Beneficiary Participation on Governing and Advisory Boards:** As part of the three-way contract, CMS and the State shall require Participating Plans to obtain consumer and community input on issues of program management and Enrollee care through a range of approaches, which may include beneficiary participation on Participating Plan governing boards and quality review bodies. The ICO must also establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The ICO must also demonstrate participation of consumers with long term care needs, including Enrollees, within the governance structure of the ICO.

8. **Participating Plan Customer Service Representatives:** CMS and the State shall require Participating Plans to employ sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. Participating Plans, CMS, and the State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the Enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

9. **Privacy and Security:** CMS and the State shall require all Participating Plans to ensure privacy and security of Enrollee health records, and provide for access by Enrollees to such records as specified in the three-way contract.

10. **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.

11. **Limited Cost Sharing:** Participating Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including both those covered by both Medicare Part D and Medicaid), Plans will not charge copays, because eligible individuals residing in nursing homes would not currently be subject to such payments, and individuals receiving HCBS in a Medicaid waiver program would also not be subject to Part D copays. Participating Plans also will not assess any other Medicaid copays, as individuals who reside in nursing homes are exempt from such copays, and this policy will be extended to individuals who relocate in Wisconsin's Integrated Demonstration. Other Medicaid cost-sharing as required for beneficiary eligibility in certain Medicaid managed long term care programs based on patient liability or post eligibility treatment of income will continue to apply,.

12. **No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for covered services.

13. **Bill of Rights:** Beneficiaries will also have all protections listed in the Wisconsin Integrated Demonstration Bill of Rights in Appendix Y.

F. INTEGRATED APPEALS AND GRIEVANCES

1. **Participating Plan Grievances and Internal Appeals Processes:** CMS and the State agree to develop a unified set of requirements for Participating Plan grievances and internal appeals processes that incorporate relevant requirements that are at least as beneficiary-friendly as Medicare Advantage, and Medicaid managed care, to create a more beneficiary-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All Participating Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Part D appeals and grievances will continue to be managed under existing Part D rules, and non-Part

D pharmacy appeals will be managed by the State. CMS and the State will work to continue to coordinate grievances and appeals for pharmacy.

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

G. ADMINISTRATION AND REPORTING

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

   These activities shall include but not be limited to:

   - Reviewing and analyzing relevant data as agreed in Appendix 7 and the three-way contracts, enrollment and disenrollment reports.[2]
   - Reviewing any other performance metrics applied for quality withhold or other purposes.
   - Reviewing reports of Enrollee complaints, reviewing compliance with applicable integrated CMS and State Medicaid Agency standards as outlined in this MOU and the three-way contracts, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.

[2] Reporting requirements are an issue that may require further discussion in MOU finalization and/or three-way contract processes.

- Reviewing and analyzing reports on Participating Plans' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste and abuse as may be agreed upon by CMS and the State, and ensuring that Participating Plans take corrective action, as appropriate.
- Reviewing and analyzing reports on Participating Plans' network adequacy, including the Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
- Reviewing any other applicable ratings and measures.
- Responding to and investigating beneficiary complaints and quality of care issues.

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

    - The State and CMS will each retain, yet coordinate, current responsibilities toward the beneficiary such that beneficiaries maintain access to their benefits across both programs.

    - CMS and the State will leverage existing protocols (for example, in responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve beneficiary access problems in real-time.

    - Oversight will be coordinated and subject to a unified set of requirements. CMS-State contract management teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the State and CMS.

    - Oversight of the Participating Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the State's Medicaid managed care programs.

    - Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. Demonstration Plans will be

included in all existing Medicare Part D oversight activities, and may be included in existing Medicare Advantage oversight activities as agreed in this MOU and three-way contracts, possibly including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.

- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools or developing integrated methods where applicable and possible, 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[3]:** CMS and the State shall define and specify in the three-way contract a Consolidated Reporting Process for Participating Plans that ensures the provision of the necessary data on diagnosis, HEDIS and other quality measures, Enrollee satisfaction and evidence-based measures and other information as may be beneficial in order to monitor each Participating Plan's performance. Participating Plans will be required to meet the encounter reporting requirements that are established for the Initiative. See Appendix 7 for more detail.

4. **Accept and Process Data:** CMS, or its designated agent(s), and the State shall accept and process uniform person-level Enrollee Data, for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and the State shall integrate and streamline data submissions for Participating Plans wherever practicable.

[3] Reporting requirements are an issue that may require further discussion in MOU finalization and/or three-way contract processes.

H. QUALITY MANAGEMENT

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

2. **External Quality Reviews:** CMS and the State shall coordinate the Participating Plan external quality review(s) conducted by the Quality Improvement Organization (QIO) and/or External Quality Review Organization (EQRO).

3. **Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the Participating Plans' compliance with those standards. These standards are articulated in Appendix 7 and the Participating Plan three-way contract.

I. FINANCING AND PAYMENT

1. Rates and Financial Terms: For each calendar year of the Demonstration, before rates are offered to Participating Plans, CMS shall share with the Commonwealth 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 Participating Plans for the Medicare A/B and Part D components of the rate. The Commonwealth

will make a payment to the Participating Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the three-way contract, for collecting or ensuring the Participating Plans or their contractors collect and report to CMS and the State the data needed for the CMS evaluation.

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

K. EXTENSION OF AGREEMENT

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 AGREEMENT

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 State, the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the Parties to any current or future expenditure of resources or from modifying the Medicare and Medicaid programs as allowed under the respective federal laws and regulations. This MOU does not obligate any funds by either of the Parties. Each party acknowledges that it is entering into this MOU under its own authority.

2. **Modification of this Agreement:** Either CMS or the State may seek to modify or amend the MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

3. **Termination of this Agreement** is allowed under the following circumstances:

a. Termination without cause - Except as otherwise permitted below, a termination of this MOU by CMS or the State for any reason will require that CMS or the State provides a minimum of 90-day advance notice to the other party, 90-day advance notice to the Participating Plans, and 60-day advance notice to Enrollees and the general public.

b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

c. Termination for cause - Either party may terminate this Agreement upon 30 days' notice due to a material breach of a provision of this MOU or the three-way contract.

d. Termination due to a Change in Law - In addition, CMS or the State may terminate this agreement upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

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

4. Demonstration phase-out: Any planned termination at the end of the Demonstration must follow the following procedures:

a. Notification - Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than five (5) months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.

b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices, including information on the beneficiary's appeal rights, and if applicable, the process by

which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, including plans for making an appropriate referral for enrollment of all Enrollees in a Medicare Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing ICO and State responsibilities and close-out costs. If the Demonstration is terminated as set forth in Paragraphs 3a.- 3d. above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees. 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 - The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. If applicable, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. FFP - If the Demonstration is terminated by either party, or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling participants.

M. SIGNATURES

This MOU is effective on this day forward [August 22, 2013] through the end of the Demonstration period [December 31, 2016].4 Additionally, the terms of this MOU shall continue to apply to the State and Participating Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of Wisconsin 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 (Date)
Administrator

State of Wisconsin, Department of Health Services:

(Date)

Secretary, Department of Health Services

[4] Dates will be revised once timelines are known.

Appendix 1: Definitions

Appeals - an Enrollee's request for review of a Participating Plan's (Integrated Care Organization's) coverage or payment determination.

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.

Care Coordinator - a trained individual from any appropriate profession, as specified in the three way contract and based on the enrollee's needs, employed or contracted by the ICO who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about all services; participating in the MDS assessment for nursing home residents or other assessments for enrollees who relocate to the community; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (IDT), coordinates and facilitates meetings and other activities of those IDTs. The Care Coordinator also participates in assessments of each Enrollee on whose IDT he or she serves.

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

CMS - Centers for Medicare & Medicaid Services.

Contract - the participation agreement that CMS and the State have with an ICO for the terms and conditions pursuant to which an ICO may participate in this Demonstration.

Contract Management Team - a group of CMS and Wisconsin Department of Health Services representatives responsible for overseeing the contract.

Covered Services - the set of services to be offered by the Participating Plans (Integrated Care Organizations).

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

Cultural Competence - understanding those values, beliefs, and needs that are associated with patients' 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 - any dual eligible individual who is enrolled in an ICO.

Enrollment - the processes by which an individual who is eligible for the Demonstration is enrolled in a Participating Plan. Such processes include completion of an enrollment form or application in order to become a member of an ICO. (Passive enrollment is defined below.)

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

Full-benefit Medicaid – Any Medicaid benefit plan providing the full set of Medicaid State Plan services. In Wisconsin Medicaid, these benefit plans include: Medicaid, Medicaid waiver, Foster Care MA, Medical Assistance Purchase Plan, Medical Assistance Purchase Plan Waiver, BadgerCare Plus Standard Plan, and Well Woman Medicaid

Grievances – An expression of enrollee dissatisfaction about any matter other than a coverage or payment determination.

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.

Independent Living and Long Term Services and Supports (LTSS) - a wide variety of services and supports that help frail elderly and people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities**.**

Individualized Care Plan - the plan of care developed by an Enrollee and an Enrollee's Interdisciplinary Care Team.

Integrated Care Organization (ICO) - a health plan contracted to provide integrated care to Enrollees. All Participating Plans shall be designated as ICOs and be held accountable for providing integrated care.

Interdisciplinary Care Team (IDT) - a team including the Enrollee, a Care Coordinator, and any other of a range of members having expertise appropriate to each Enrollee based on that Enrollee's specific needs, and other individuals at the discretion of the Enrollee, that work with the Enrollee to develop, implement, and maintain the Individualized Care Plan. The range of expertise potentially included on an IDT is expected to include social workers, nurses, nurse practitioners, paraprofessionals, peer support specialists, pharmacists, and medical practitioners, including those with diagnosis and target group expertise.

Long Term Care Functional Screen (LTCFS) – A screening tool to collect information about an individual's functional status, health, and need for assistance, used to determine functional eligibility for certain long-term care programs. Experienced professionals, usually social workers or registered nurses, who have taken training and passed a certification exam, administer the screen.

Medically Necessary Services - services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medicaid. Medically necessary services will be those that are allowable under either Medicare or Medicaid, and further determined by the IDT via the Resource Allocation Decision (RAD) method to be appropriate to address an individual's needs. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC 1395y. The Resource Allocation Decision (RAD) method will be the means of determining which service or services are best suited to diagnose or treat illness or injury or improve functioning for this demonstration, and will consider Medicare national and local coverage determinations as a source of policy guidelines.

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 and B and eligible for and receiving full-benefit Medicaid.

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

Medicaid Stay – A stay in a nursing home that is fully paid by Medicaid. This does not include the portion of a Medicare stay wherein Medicaid may pay a copayment or cost share.

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

Medicare Waiver - generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

Medicaid Waiver - generally, a waiver of existing law authorized under Section 1115(a),

1115A, or 1915 of the Social Security Act.

Minimum Data Set (MDS): A core set of screening, clinical, and functional status elements which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The MDS is a key component of the nursing home Resident Assessment Instrument (RAI), and is required at specified intervals for Medicare and Medicaid nursing home residents.

Participating Plan - a health plan or other qualified entity serving as an Integrated Care Organization jointly selected by the State and CMS for participation in this Demonstration.

Participating Nursing Home – a nursing home that has met provider credentialing criteria and signed a contract with one more ICOs to serve its Enrollees in the demonstration. Nursing homes are defined as in Wisconsin Statute Chapter 50, except that Intermediate Care Facilities for Individuals with an Intellectual Disability (ICFs-IDD), formerly known as ICFs-MR or FDDs, are not eligible to participate.

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

Privacy - requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant Wisconsin privacy laws.

Readiness Review - prior to entering into a three way agreement with the State and CMS, each Integrated Care Organization 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 the State 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.

Resource Allocation Decision (RAD) - The RAD method balances outcomes and enrollee preferences to authorize the service intervention option that most effectively meets the specified care plan goal. The process to authorize services via the RAD method includes identifying the need, goal, or problem; determining how it relates to the member's assessment, plan, and desired outcomes; considering how to meet the need, relevant policy guidelines, member and/or family preference, and effectiveness and cost effectiveness. The method is described further in Appendix X.

Solvency - standards for requirements on cash flow, net worth, cash reserves, working capital

requirements, insolvency protection and reserves established by the State and agreed to by CMS.

State - the State of Wisconsin.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 14-15; DHS Response to CMS Questions pp. 1-2
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 9-11, 15; DHS Response to CMS Questions pp. 2-9
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss the proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 16-19; Cover memo listing changes to proposal

	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. 20-21
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:	
	Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards).	pp. 16-21 (Stakeholder Engagement); Phase One Certification requirements included in "WI Differences from FAD" document attached to DHS Response to CMS Questions
	Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	p. 21; Marketing & Member Materials proposal included in "WI Differences from FAD" document attached to DHS Response to CMS Questions; subsequent revisions as described in MOU

	Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	Phase One Certification requirements included in "WI Differences from FAD" document attached to DHS Response to CMS Questions
	Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pp. 9-10, 14-15, 19-20
	Ensure access to services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer Enrollee questions and respond to complaints/concerns appropriately.	pp. 19-21; Marketing & Member Materials proposal included in "WI Differences from FAD" document attached to DHS Response to CMS Questions; subsequent revisions as described in MOU
	Ensure an adequate and appropriate provider network, as detailed below.	pp. 13; updated requirements as described in MOU
	Ensure that beneficiaries are meaningfully informed about their care options.	pp. 21; DHS Responses to CMS Questions; Outreach & Enrollment Overview and Marketing & Member Materials Proposal included in "WI Differences from FAD" document attached to DHS Response to CMS Questions
	Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	
	o *For Capitated Model*, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.	pp. 19-21; Appeals & Grievances proposal attached to DHS Response to CMS Questions

	o *For Managed FFS Model*, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.	
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 30-33
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 13; Provider Network requirements refined in this MOU

Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 25-26, 32-33; Encounter Reporting Proposal included in "WI Differences from FAD" document attached to DHS Response to CMS Questions
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;	pp. 7-8, Appendix 1A; subsequent data releases published on website
	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	None currently planned
	State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.	Not applicable

Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 11-13 & referenced Appendices, p.21, p. 33; Outreach & Enrollment Plan Summary included in "WI Differences from FAD" document attached to DHS Response to CMS Questions; Revised Roll-Out Plan subsequently submitted to CMS and posted on website
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp. 24-25; additional financial modeling & data posted on Wisconsin Integrated Demonstration website
Public Notice	State has provided sufficient public notice, including:	
	·At least a 30-day public notice process and comment period;	pp. 18-19
	·At least two public meetings prior to submission of a proposal; and	pp. 18-19
	·Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	p.17 (tribal representation on Stakeholder Advisory Committee); planned consultations regarding waiver submissions once developed
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones **by end of 2012**:	
	·Meaningful stakeholder engagement.	pp. 20-21; ongoing Stakeholder Advisory Committee work

	·Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.	1915 (a) and (c) waivers under development.
	·Receipt of any necessary State legislative or budget authority.	No additional legislative or budget authority is expected to be necessary.
	·Joint procurement process (for capitated models only).	pp. 11-12; certification documents subsequently released and included in "WI Differences from FAD" document attached to DHS Response to CMS Questions
	·Beneficiary outreach/notification of enrollment processes, etc.	pp. 21; Outreach & Enrollment Summary included in "WI Differences from FAD" document attached to DHS Response to CMS Questions

Appendix 3: Details of State Demonstration Area

All service areas with one or more successful ICO certifications.

I. ICO Certification: The demonstration area will include all service areas as defined in the below roll-out schedule with one or more successful ICO certifications.

II. Roll-Out Schedule: The demonstration area will include counties in Wisconsin in which ICOs are certified to implement the demonstration at any point during an 18-month roll-out period. Specific implementation dates for each county and each ICO will be established in certification and contracting processes.

   a. Implementation date: The date upon which the demonstration will begin is [INSERT ONCE KNOWN]. This will be the first possible enrollment effective date and the date that the ICO(s) certified in the first implementation county or counties will begin providing services to participants.
   b. Implementation in a county may occur on the first day of any month in the 18 month roll-out period, as determined by certification processes and contracts, so long as at least one ICO is certified in that county.
   c. Roll out period: The roll-out period is the 18 months following the implementation date; that is January 1, 2014 through June 30, 2015.[5] After the end of the roll-out period:
      i. Wisconsin Integrated Demonstration may not be implemented in any additional counties;
      ii. No new ICOs may begin operating a Wisconsin Integrated Demonstration program;
      iii. No existing ICOs may begin operating in a county other than those in which they operate at the end of the roll-out period; and
      iv. Residents in any nursing home not already participating in Wisconsin Integrated Demonstration at the end of the roll-out period may not be enrolled in the demonstration.

[5] Update dates once timeline is known.

Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to Participating Plans and their sponsoring organizations for the Demonstration period beginning January 1, 2014 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the three-way contracts.

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

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

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR, Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in ICOs to Medicare-Medicaid beneficiaries who are between the ages of 21 and 64, including beneficiaries who may have end-stage renal disease, and (2) the passive enrollment process provided for under the Demonstration.

- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments 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 does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR 422.2266 and 423.2266, with respect to marketing and Enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.

- Sections 1852 (f) and (g) and implementing regulations at 42 CFR Part 422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.

- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than $0, to permit Participating Plans to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning January 1, 2014 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the three-way contracts.

1115A Medicaid Waivers

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

1. Statewideness **Section 1902(a)(1)**

To enable Wisconsin to provide managed care plans or certain types of managed care plans (ICOs for Medicare-Medicaid Enrollees) only in certain geographical areas of the State.

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

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

Actuarially sound capitation rates for this Demonstration refer to the total capitation rates paid to Participating Plans, including both Medicare and Medicaid contributions. For Medicare-Medicaid beneficiaries, 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.

1915(a) Medicaid Managed Care Authority

Under the authority of Section 1915(a) of the Social Security Act (the Act), Wisconsin shall not be deemed out of compliance with paragraphs (10) or (23) of section 1902(a) under this demonstration. This authority will be established in the contract approval process established under this demonstration based on the waiver of Section 1903(m)(2)(A)(iii) as implemented in 42 CFR 438.6 described above.

1. Comparability **Section 1902(a)(10)**

The uniquely designed benefit package for the particular population described in this MOU shall not be deemed out of compliance with the comparability requirements of Section 1902(a)(10).

2. Freedom of Choice **Section 1902(a)(23)**

Restriction of the providers from which an individual can receive items or services to those authorized in the plan of care as described in this MOU shall not be deemed out of compliance with the freedom of choice requirements of Section (1902)(a)(23) if individuals have reasonable access as required by 1915(a)(2)(B) and as established by the network adequacy procedures described in this MOU and the three-way contract.

1915(c) Medicaid Waivers

Wisconsin will amend or submit new 1915(c) waivers to include provision of HCBS in the demonstration.

Appendix 6: Payments to Participating Plans

The Centers for Medicare and Medicaid Services (CMS) and the State of Wisconsin 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 Participating Plans are responsible for the full range of services covered under the Demonstration;
(3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare A/B components; and
(4) Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

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

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates[6]
1	April 1, 2013 – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016

[6] To be revised once timelines are known.

Figure 6-2: Summary of Payment Methodology under Wisconsin Demonstration to Integrate Care for Dual Eligible Beneficiaries

State: State of Wisconsin

Rate Element	Medicare A/B	Medicare D	Medicare for Hospice in the NH	Medicaid
Baseline costs for the purposes of setting payment rates Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county. Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.	Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service weighted by where dual eligibles 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.	National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending. Note that additional costs associated with low-income subsidy payments, reinsurance payments, and risk-sharing are included in the Part D baseline for the purposes of tracking and evaluating Part D costs but not for the purposes of setting payment rates. These amounts will be factored into plan payments, but these amounts are subject to	For nursing home residents electing hospice, the base costs will be the hospice per diem plus an additional PMPM amount based on average FFS costs for hospice physician claims and other FFS claims unrelated to the terminal diagnosis.	Historical State data. Trend rates developed by State actuaries based on State Plan services, with oversight from CMS contractor and staff; projections completed by State actuaries with oversight from CMS.

Rate Element	Medicare A/B	Medicare D	Medicare for Hospice in the NH	Medicaid
		reconciliation consistent with Part D reconciliation rules.		
Responsible for producing data	CMS	CMS	CMS. State Medicaid agency can assist in analysis of hospice claims for WI NH residents if needed.	State Medicaid agency, validated by CMS
Savings percentages	Demonstration Year 1: 1% Demonstration Year 2: 1.25% Demonstration Year 3: 1.5%	Not Applicable	Demonstration Year 1: 1% Demonstration Year 2: 1.25% Demonstration Year 3: 1.5%	Demonstration Year 1: 1% Demonstration Year 2: 1.25% Demonstration Year 3: 1.5%
Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	None- separate rate category for subset with specific, distinct, and consistent cost profile.	State will use MDS-based risk adjustment method as described in section I
Quality withhold	Applied Demonstration Year[7] 1: 0.5% Demonstration Year 2: 0.75%	Not applied	Applied TBD- may apply different quality	Applied Demonstration Year[1] 1: 0.5% Demonstration Year 2: 0.75%

7 Quality withholds may be applied based on an ICO's year of operations rather than a Demonstration Year; see details in section VI.C below.

Rate Element	Medicare A/B	Medicare D	Medicare for Hospice in the NH	Medicaid
	Demonstration Year 3: 1%		measures or withholds or no withhold.	Demonstration Year 3: 1%
Risk Sharing	Combined (all eligible costs except Part D) ICO-level tiered risk corridors will be applied, in Demonstration Year 1 only	Existing Part D processes will apply	Combined (all eligible costs except Part D) ICO-level tiered risk corridors will be applied, in Demonstration Year 1 only	Combined (all eligible costs except Part D) ICO-level tiered risk corridors will be applied, in Demonstration Year 1 only

I. Underlying Rate Structure for Medicaid Components of the Rates

The Medicaid rate will have one rate cell, as all enrollees will be in the nursing home population at the time of enrollment. Enrollees may subsequently relocate, but will likely retain a NH LOC and therefore the Medicaid rate will be based on institutional data and risk adjustment methods. No or very few enrollees are expected to lose the NH LOC; therefore, DHS and its actuaries expect that no separate rate cell is needed, nor could costs reliably be estimated, for individuals able to relocate to the community who subsequently are no longer at a NH LOC.

DHS will work with its actuaries to develop a risk adjustment model that adjusts the acute & primary portion of the Medicaid rate based on individuals' diagnoses using the HCC adjustment system and that adjusts the long term care portion of the Medicaid rate using data from the Minimum Data Set (MDS). This is similar to the risk adjustment model for Wisconsin's current Family Care – Partnership program, except that the long term care adjustment will be developed using MDS rather than Long Term Care Functional Screen (LTCFS) data.

The long term care portion, which is the larger share of the Medicaid rate, will be risk adjusted using regression models to predict costs. Regression is a statistical technique that produces an estimate of the effect of each factor individually on the cost for an individual. The regression model may include either MDS assessment variables or RUGS classifications derived from MDS variables, and may also consider facility-level variables such as facility type.

The regression model will be applied to the MDS assessment data and the HCC model to diagnostic and demographic information from claims and eligibility records for eligible nursing home residents to produce the prospective Medicaid capitation rate for each ICO. This prospective rate will be retroactively adjusted for the acuity of actual enrollees as discussed further in section XI below. The regression models and specific rates will be detailed in a Medicaid rate report to be published on DHS' website prior to the implementation date of the

demonstration.

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

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

A. Medicaid:

a. Prior to implementation of the Demonstration, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration using the most recent data available. The baseline will take into account historic costs, and will be trended forward to the Demonstration period.

Baseline data will be calculated using historic data at least through calendar year 2010, but CMS may update in subsequent years for more recent historical State data. CMS will review and validate the Medicaid baseline data.

b. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration at the beginning of the Demonstration period to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).

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

d. The State may combine some counties into larger regions, with regional rates.

e. Except for updates based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS and the State determine the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

B. Medicare Part A/B:

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

b. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates, the Medicare FFS standardized county rates for each year, and the baseline hospice costs for NH residents, 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. The hospice baseline will include per diem payments to hospice organizations and the PMPM cost of hospice physician and non-terminal diagnosis FFS claims.

c. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.

d. Baseline spending under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the State's Demonstration for each year, with a separate PMPM calculated for hospice in the NH and the baseline blended as described above. For most enrollees, beneficiary risk scores will be applied to the standardized payment rates at the time of payment. For enrollees receiving hospice in the NH, because the hospice PMPM is a separate rate category for a specific subset with a distinct and consistent cost profile and the standard risk score calculation is not calibrated to the hospice subset, a risk score will not be applied.

e. Depending on the definition of the Demonstration-eligible group, CMS may require the State to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. DHS and CMS will jointly determine 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 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 2013 is 3.41%. Virtually all new ICO Enrollees will come from Medicare FFS, and 2013 ICO risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the ICOs themselves. Therefore, CMS will not apply the coding intensity adjustment factor in calendar year 2013 to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. After calendar year 2013, 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 2013 Part D NAMBA is $79.64.

III. Aggregate Savings Percentages Under the Demonstration

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

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

a. Demonstration Year 1: 1%

b. Demonstration Year 2: 1.25%

c. Demonstration Year 3: 1.5%

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

IV. Apply 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 per capita baseline estimates to determine standardized Demonstration payment rates. The Medicaid savings percentages may vary by region and/or target group, but will in the aggregate equal the savings percentages identified above. Changes to the savings percentages under section III of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

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

V. Risk Adjustment Methodology

A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in sections II.B.d and II.B.g of this Appendix, the existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.

B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

C. The Medicaid component will be risk adjusted based on a methodology proposed by the State and agreed to by CMS as described above in Section I.

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

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

B. Withhold Measures in Demonstration Year 1.

a. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 0.5% withhold. Measure specifications and required thresholds will be included in the three-way contract.

b. Because Demonstration Year 1 crosses calendar/contract years, Participating Plans will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2013 and CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.[8]

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

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Access to Care (for CY 2014 only)	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS	X	X
Customer Service (for CY 2014 only)	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	X

C. Withhold Measures in Demonstration Years 2 and 3.

a. The quality withhold will increase to 0.75% in the second year that a given ICO operates a demonstration plan (may be Year 2 or Year 3 depending on the ICO and the details of the roll-out plan) and 1% in the third year that a given ICO operates a demonstration plan (may be Year 3 or not occur within the three year demonstration, depending on the ICO and the details of the roll-out plan) and will be based on performance on the core Demonstration and State specified measures.

[8] Update as needed once timelines are known.

Figure 6-4 below identifies the CMS core quality withhold measures for Demonstration Years 2 and 3. The State may add additional withhold measures in the three-way contract based on measures selected for an ongoing project to establish a nursing home based quality measurement system.[9]

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

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State Specified Measure
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D medication adherence for oral diabetes medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
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	NCQA/HEDIS		X

9 Discussed further in Appendix 7.

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State Specified Measure
	with a diagnosis of AOD within 30 days of the initiation visit.			
Timely transmission of transition record.	Percent of Demonstration participants 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
Quality of life measure TBD	To be determined – specified in three-way contract.			X

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

b. Additional detail regarding the agreed upon measures, including technical specifications and required thresholds, will be specified in the three-way contract. Metrics only applicable to younger individuals based on technical specifications will be adjusted or removed, if there is an insufficient denominator based on the number of individuals in a given age category to reflect the State's primarily elderly Demonstration target population.

VII. Payments to Participating Plans

A. CMS will make separate monthly risk-adjusted payments to the Participating Plans for the Medicare A/B and Part D components of the rate, and for the separate Medicare rate for hospice in the NH, 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 Participating Plans for the Medicaid component of the rate.

C. The blended payment from CMS and the State is intended to be adequate to support access to and utilization of covered services, according to Enrollee Individualized Care Plans. CMS and the State will jointly monitor access to care and overall financial viability of Plans accordingly.

VIII. Evaluate and Pay Participating Plans Relative to Quality Withhold Requirements

A. CMS and the State will evaluate Plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each Participating Plan from each payor.

B. Whether or not each Plan has met the quality requirements in a given year will be made public, as will relevant quality results of Participating Plans in Demonstration Years 2 and 3.

IX. Medical Loss Ratio (MLR)

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

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

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

X. Risk Mitigation Strategies

- **Retroactive Acuity Adjustments:** For the first year of the demonstration's implementation in a given county, the prospectively estimated Medicaid rate will be retroactively adjusted based on the MDS assessment data of actual enrollees in the demonstration.

    A. Given the roll-out schedule described in Appendix 3, the first counties to implement will receive retroactive adjustments only in Year 1, as the demonstration will have been implemented for a full year in a given county by Year 2, while other counties will receive retroactive adjustments as late as Year

2 or the first half of Year 3 if the demonstration is implemented there at the very end of the roll-out period.

B. Retroactive adjustments will not occur for individuals who relocate and no longer have MDS assessment data.

C. Retroactive acuity adjustments will be calculated quarterly. If the quarterly calculation results in an acuity adjustment greater than 10% of the Medicaid capitation revenue for the ICO for the quarter, the payment will be made for the quarter; otherwise, final retroactive acuity adjustments will be paid at the end of the year. Calculation details and schedules will be described in the three-way contract.

- Risk Corridors will be established for Demonstration Year 1 in order to account for possible enrollment bias and to protect Plans and payors 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 the State will evaluate encounter data, cost data, and ICO financial reports to determine ICO incurred costs of services and care 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. Risk corridors will consider both service and care management costs.

    C. Risk corridor tiers

        - CMS and the State will establish specific percentage thresholds for the following bands in the three-way contract to address potential Participating Plan gains/losses in Demonstration Year 1:

            1. In the top corridor above a specific percentage gain/loss to be no higher than 15.0%, Participating Plans would bear 100% of the risk/reward.

2. Within one or more corridors to be specified in the three way contract gain/loss, Participating Plans would bear a portion of the risk/reward; the State and CMS would share in the other portion, as described in B above. The lower bound of the first corridor within which risk is shared shall be at least 1% and the upper bound of the highest corridor within which risk is shared shall be no more than 15%; one or more corridors within this range may be defined. The State and CMS share within this corridor shall be less than 100% of the loss. The specific percentages to define the corridors between 1% and 15%, as well as the specific percentage of gain/loss shared by the State and CMS within those corridors, will be defined in the three-way contract.

3. Between 0% and the lower percentage threshold for the corridor described in C.2 above gain/loss, Participating Plans would bear 100% of the risk/reward.

- Risk Mitigation Process: In the event that broad risk corridor payments or receipts in Section IX are incurred, CMS will convene the following parties to assess the factors resulting in the payment or loss and, as warranted, evaluate the payment parameters, including the respective projected baselines, savings percentages, and risk adjustment methodology: (1) CMS participants: Administrator, Chief Actuary, Director of the Center for Medicare, Director of the Center for Medicaid and CHIP Services, Director of the Medicare-Medicaid Coordination Office; (2) Office of Management and Budget participants: Medicare Branch Chief, Medicaid Branch Chief; (3) State participants: Medicaid Director or designee. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings. Cost reconciliation under Part D will continue as is under the Demonstration. CMS will monitor Part D costs closely on an on-going basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.

- **Vent-Dependent Payments:** Consistent with Medicaid policy in other managed care programs, DHS will reimburse ICOs on a cost basis for the Medicaid portion of services provided to ventilator assisted patients enrolled in the ICO who meet certain criteria to be detailed in the three-way contract. The criteria will include requirements for total respiratory support, type of equipment needed, hours and days for which total respiratory support is required, and documentation of necessity of total respiratory support. Payments will be made based on data submitted via encounter reporting, and may be adjusted based on analysis or validation of the split of Medicaid and Medicare costs reported in encounter data. Reimbursement already provided to the ICO in the form of capitation payments will be deducted from reimbursement payment for Medicaid costs.

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

A. Rates will be updated using a similar process for each calendar year. The Medicaid rate will be updated annually applying the risk adjustment methodology described in V to the most updated estimate of the enrolled population for a given year, and to apply that year's savings and quality withhold percentages along with an updated estimate of Medicaid trend. The Medicare rate will be updated with the annual adjustments to Medicare baseline rates, yearly savings and quality withholds. Other changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes in Federal law and/or State policy; and changes in coding intensity.

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

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

C. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Payment methodologies described in Appendix 6 may require further revision during MOU finalization and/or three-way contracting based on additional analysis.

Appendix 7: Demonstration Parameters

The purpose of this Appendix is to describe the parameters that will govern this Federal-State partnership. CMS and the State have negotiated these parameters, as specified below.

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

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

The Wisconsin Department of Health Services (DHS) is the single state agency for the Medicaid program. The Health Services Secretary directly oversees the DHS divisions and offices that will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across DHS as described below.

Within DHS, the Division of Long Term Care (DLTC) will have responsibility for implementation and oversight of the demonstration. The Wisconsin Integrated Demonstration team within the Bureau of Financial Management in DLTC will be primarily responsible for program implementation and oversight activities. For ICO oversight, ICO-specific teams will include Wisconsin Integrated Demonstration dedicated staff and other DLTC staff who oversee the entities contracting as ICOs in other managed long term care programs. DLTC teams will also interface with other divisions on reporting and regulatory issues. This will include interaction with the Division of Quality Assurance to coordinate on nursing home oversight and regulatory issues

II. Plan or Qualified Entity Selection

The State and CMS will engage in a joint certification process that will take into account previous performance in Medicare and Medicaid, and ensure that ICOs have met integrated, jointly agreed requirements, as specified in this MOU. DHS has issued a Phase One Certification document that included preliminary State requirements to become an ICO under this Demonstration. Subsequent phases of this certification process will require additional documentation of ICO capacity to operate the demonstration as agreed by DHS and CMS. DHS and CMS may also plan another round of certification to allow additional organizations to apply for certification as ICOs. This section is subject to update, and any updates will be reflected in certification process documents and in the three-way contract.

III. State Level Enrollment Operations Requirements

a. Eligible Populations/Excluded Populations - As described in the body of the MOU.

b. Enrollment and Disenrollment Processes - All enrollments and disenrollment-related transactions will be processed through Wisconsin's interChange system. DHS (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions.

c. Uniform Enrollment and Disenrollment Letter and Forms - Letters and forms will be appended to the three-way contract when they are completed and agreed to by both CMS and the State.

d. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollment is the first day of the month following receipt of an eligible beneficiary's request to enroll, or the first day of the month following the month in which the beneficiary is eligible, as applicable for an individual Enrollee. Passive enrollment is effective not sooner than 60 days after beneficiary notification.

   i. ICOs will be required to accept enrollments two months prior to the date on which they begin providing coverage .

   ii. The State will initially conduct a passive enrollment period effective the first date of the month in which the demonstration begins in a given county, subject to Participating Plans meeting CMS and State requirements including Plans' capacity to accept new Enrollees. The State will provide notice of passive enrollments at least 60 days prior to the effective dates to eligible individuals, and will accept opt-out requests prior to the effective date of enrollment. Individuals who otherwise would be in the voluntary enrollment eligible group due to enrollment in another plan or program who subsequently disenroll from the other plan or program will be eligible for passive enrollment, with an opportunity to opt-out, into a Demonstration Plan upon their disenrollment from the other plan or program.. The State and CMS must agree in writing to any changes to the enrollment effective dates.

   iii. Following this start-up period, members who are eligible for the Demonstration and who have neither selected a Plan nor opted out of the

Demonstration will receive a notice of passive enrollment into an ICO and an enrollment package that describes their options, including that of opting out of the Demonstration. Members will then have 60 days to select a different ICO or opt out of the Demonstration. DHS will proceed with passive enrollment into the identified ICO for Members who do not make a different choice, with an effective date of the first day of the month following the end of the 60-day period.

iv. Requests to disenroll will be accepted at any point after enrollment occurs and are effective on the first of the following month.

e. No enrollments will be accepted within 6 months (or less) of the end of the Demonstration.

f. Notification of passive enrollment options will be provided by the State to each beneficiary not less than 60 calendar days prior to the effective date of the proposed enrollment.

g. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.

h. If there is more than one ICO serving a given county and nursing home, the State will work to develop an "intelligent assignment" algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services), with further details to be provided in the three-way contracts.

i. The State will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt out to CMS via transactions to CMS' MARx system, or via a third party CMS designates to receive such transactions. Beneficiaries will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1800-Medicare, will remain a resource for Medicare beneficiaries.

i. The State will provide notices, as approved by CMS, to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook.

j. Data in State and CMS systems will be reconciled on a timely basis to prevent discrepancies between such systems.

IV. State Level Delivery System Requirements

a. Provision of Integrated Care Services

i. State Requirements for Care Coordination - ICOs will provide care coordination services to all Enrollees through an Interdisciplinary Team (IDT) that will coordinate all medical, behavioral health, and long term care services. Primary care providers will participate on the IDT and offer integrated primary care and behavioral health services.

ICOs' care coordination models shall include evidenced based-practices to prevent hospitalizations and an established structure to improve management of transitions between care settings, and best practices to meet other care coordination goals as established by the ICO or dictated in the three-way contract.

ii. State Requirements for an Interdisciplinary Care Team – ICOs will support an Interdisciplinary Team (IDT) for each member, which will ensure the integration of the member's medical, behavioral health, and long term care. The IDT will be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

1. ICOs will make available a range of care coordination expertise appropriate to the acuity and complexity of the ICO's members, with expertise available to each member based on that member's specific needs. This range is expected to include care coordinators, social workers, nurses, nurse practitioners, paraprofessionals, peer support specialists, pharmacists, and medical practitioners, including those with diagnosis and target group expertise.

2. The intensity, frequency, and types of IDT involvement will be based on the needs of the member, coordinated with existing nursing home care planning processes and regulatory requirements, and meet any additional standards established in the three-way contract.

3. ICOs must establish training protocols for all members of the IDT , to include training on the person-centered planning processes, the Wisconsin Integrated Demonstration Bill of Rights, and other training topics to be established in the three-way contract.

iii. State Requirements for member Assessment, Care Planning, Monitoring and Continuous Improvement.

1. Assessments for Nursing Home Residents - For each enrollee in the nursing home, the ICO shall review the nursing home's most recent Minimum Data Set (MDS) assessment upon enrollment, and participate in subsequent assessments as agreed with the nursing home. The ICO may conduct its own supplemental assessments as the IDT identifies necessary, but any other ICO assessments shall supplement, rather than duplicate or replace, the MDS assessments required by regulation. .

2. Assessments for Enrollees in the Community: For enrollees who relocate to the community, the ICO will use the Long Term Care Functional Screen (LTCFS) to establish eligibility for HCBS, and supplement the LTCFS with its own comprehensive assessment of medical, behavioral health, and LTSS needs. Any specific requirements for comprehensive assessments outside of a nursing facility will be detailed in the three-way contract.

3. Individualized Care Plans: The MDS will be the starting point to supplement or revise the existing nursing home plan of care to create an Individualized Care Plan for enrollees residing in a nursing home, and the LTCFS and comprehensive assessments will be the starting point to create an Individualized Care Plan for an enrollee in the community. Care plans will center on the enrollee's values, strengths, personal support and care network, and broadly-defined support and care needs, and will include medical, behavioral, and/or long term care services to support the enrollee's goals and outcomes.

   Each element of the MDS or other comprehensive assessment, including a description of all covered services to be provided until the next Individualized Care Plan review, will be reflected in the Enrollee's Individualized Care Plan, and the ICO will ensure that

all relevant aspects of the Enrollee's care are addressed in a fully integrated manner on an ongoing basis.

b. Network Adequacy –

Network Adequacy – Federal and State Medicaid and Medicare provider network adequacy criteria will be integrated for all acute and primary services to establish standards that are as stringent and as beneficiary-friendly as in existing programs, tailored to the specific demonstration population and do not require determining which payer would be primary in the existing system in order to evaluate network adequacy. CMS will retain its role in assessing provider network adequacy but will do so against the proposed integrated standards, and the State will strengthen its role to assure adequacy for acute and primary in addition to long term care services. CMS and the State will establish a joint process for reviewing and assuring network adequacy as a part of ICO certification.

Medicare standards shall apply for any covered services for which Medicare has a Medicare Advantage provider network adequacy criteria defined, excluding Maximum Travel Time to Providers measurement. Medicaid standards will apply for services that do not have Medicare network adequacy criteria defined. Furthermore, to better meet the needs of demonstration population, a more stringent Medicaid standard for the Minimum Number of Providers shall apply to the Primary Care Provider services. The following six specialties comprise the Primary Care Provider category: General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care – Physician Assistants, Primary Care – Nurse Practitioners.

The integrated requirements shall have a maximum of two service network adequacy measurements: Minimum Number of Providers and the Maximum Travel Distance to Providers. When the nursing home is primary residency for an enrollee, Maximum Travel Distance to Providers measurement shall only apply to services provided outside a nursing home.

Waivers from current Medicare requirements are required to grant the exception of Maximum Travel Time measure and limit Maximum Travel Distance measure to services provided outside a nursing home.

The integrated network standards account for the geographic county designation types (large metro, metro, micro, rural or CEAC), maximum travel distance, and minimum number of the type of providers. The State 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.

Further details defining the integrated provider network standards will be specified in the certification submission instructions and CMS and DHS contract language.

State Medicaid standards for availability to access shall apply to all long-term care services. For enrollees that relocate to the community, access to home and community based waiver services standards will be measured by timely and geographically available access for each enrollee. ICOs shall attest to having adequate capacity and/or access via evidence of internally provided services and/or subcontracted provider capacity to provide the projected membership in the proposed service area with:

- The appropriate range of services to make all services in the benefit package readily available;
- Access to prevention and wellness services;
- A sufficient number, mix and geographic distribution of providers of all services;
- Specialized expertise with the target population(s) served by the MCO;
- Culturally competent providers including Indian health care providers; and
- Services that are physically accessible and available on a timely basis.

Medicare standards shall be utilized for pharmacy benefits covered by Part D. Medicaid standards shall apply for pharmacy benefits derived from Medicaid in addition to the Part D formulary.

c. Solvency - ICOs will be required to meet solvency requirements:

    i. consistent with 42 CFR § 422.402, and

    ii. as specified in the State certification, including:

        1. Financial Viability & Stability

            a. ICOs will be licensed as insurers and will be required to comply with all Wisconsin Statute and Administrative

Code provisions related to Health Maintenance Organization Insurer (HMO) licensure and solvency, per 42 CFR § 422.402, including:

1. Wisconsin Statute Chapter 609 and Chapter 613 requirements regarding licensure and solvency.

2. Wisconsin Administrative Code Ins Chapter 9, including but not limited to capital, surplus, and insolvency protection requirements under Ins 9.04 Financial Requirements.

b. ICOs will be required to submit financial information that will be subject to review by the OCI during the certification process. Specific requirements will be defined in certification documents, and may include updated resubmission of statements or audited reports described in phase one certification requirements and additional projections demonstrating financial stability throughout the demonstration period.

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

i. The ICO provider network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified providers to meet the requirements of the three-way contract, assure access to all covered services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services;

ii. The ICO shall implement written policies and procedures that comply with integrated requirements based on 42 CFR 422.204 and 438.214 and Wisconsin statute 609.32(2) regarding the selection, credentialing, retention, and exclusion of providers as described below. The ICO shall:

1. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the ICO's provider network. The process shall meet the minimum requirements below and any other requirements established in three-way contracts.;

a. The written application to become a contracted provider must include attestation to the correctness and completeness of information in the application.

b. The ICO must verify licensure or certification for types of providers licensed or certified by a state or federal government entity, primary source verification of licensure or certification.

c. The ICO must verify that types of providers for which there is not licensure or certification are accredited or meet the ICO's own documented standards.

d. For all providers, the ICO shall not contract for or require the provider to provide services outside the scope of the provider's licensure, certification, accreditation, or other approved scope of practice.

e. The credentialing process shall consider compliance with any other State or Federal requirements relevant to the provider type, and any history of suspension or revocation of licensure or certification, disciplinary status, or liability claims against the provider.

f. Re-credentialing shall occur at least every three years and consider the above criteria in addition to performance indicators. Indicators shall be established by the plan in its written policies and procedures, and shall include:

1. Indicators related to quality and clinical outcomes, such as data from QAPI plans and/or utilization management data.

2. Indicators related to enrollee satisfaction, such as data from surveys, appeals & grievances tracking, enrollee complaints, and/or malpractice actions.

2. Establish a written policy for site visits including frequency of visits and procedures to detect deficiencies, including consideration of the site's accessibility, record keeping, and compliance with privacy requirements. Plan criteria for frequency of site visits may include:

    a. Targeting of high-volume providers or those included in grievances.

    b. For nursing facilities, review of survey results and technical assistance in addressing any deficiencies instead of a separate credentialing site visit by the ICO.

3. Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in Federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;

4. Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

5. Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or Federal law or regulation or that violates the Wisconsin Integrated Demonstration Bill of Rights , including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90and

6. Ensure compliance with program integrity policies to be detailed in the three-way contract and notify DHS and CMS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information

to DHS and CMS as required by DHS, CMS or state or Federal laws, rules, or regulations.

iii. ICOs may contract with any provider of a service covered in the benefit package (services covered under Medicare, the Medicaid State Plan, or Medicaid HCBS waivers), so long as the provider meets its requirements in the above credentialing process. If the provider meets the above requirements, then certain requirements of 42 CFR 422.204 shall not apply to Medicaid or HCBS providers in certain circumstances:

1. The requirement of 42 CFR 422.204 for providers of basic benefits to have agreements with CMS under original Medicare shall not apply if the providers have an agreement with Wisconsin Medicaid and meet other credentialing requirements.
2. The requirement of 42 CFR 422.204 that plans not contract with providers who have opted out of Medicare shall not apply if the providers participate in Medicaid in Wisconsin and meet other credentialing requirements.
3. The requirement of 42 CFR 422.204 for State licensure of providers other than physicians and health care professionals shall not apply for providers of HCBS for which State licensure does not exist (e.g. small adult family homes with one or two beds). The other credentialing requirements, including accreditation or ICO standards described above, shall apply.

V. Benefits

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

i. That are allowable under either Medicare or Medicaid, and further determined by the IDT via the Resource Allocation Decision (RAD) method. The RAD method facilitates collaboration and coordination between IDT members to balance outcomes and enrollee preferences and authorize the service intervention option that most cost effectively meets the specified care plan goal. The RAD method will be used as in Wisconsin's existing managed long term care programs and will be applied to the integrated benefit package.

The process to authorize services via the RAD method includes identifying the need, goal, or problem; determining how it relates to the

member's assessment, plan, and desired outcomes; considering how to meet the need, relevant policy guidelines, member and/or family preference, and effectiveness and cost effectiveness. The method is described further in Appendix X.

ii. (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.

1. The Resource Allocation Decision (RAD) method will be the means of facilitating collaboration and coordination between IDT members to determine the appropriate service to diagnose or treat illness or injury or improve functioning for this demonstration. Medicare national and local coverage determinations shall be a key source of policy guidelines in applying the RAD method to acute & primary services. Service authorizations may vary from these coverage determinations when the beneficiary and the rest of the IDT agree on a different service to meet the need, goal, or problem via the RAD methodology.

iii. All decisions resulting from the RAD method are subject to the member's appeal rights described elsewhere in this MOU

ICOs will be required to provide services in a way that preserves all protections to the Enrollee and provides the Enrollee with coverage to at least the same extent provided by Medicare and Wisconsin Medicaid. Coverage will be determined via the RAD method in all instances, including where benefits derived from Medicare and Medicaid overlap, except for emergency, urgent, and post-stabilization care services. Emergency, urgent, and post-stabilization care services, as defined in Chapter 4 of the Medicare Managed Care Manual, will not require determination via the RAD method or any other service authorization.

b. Supplemental Benefits - Integrated benefit package must include Medicare and Medicaid-covered benefits as well as any required Demonstration-specific supplemental items and services, and expanded State Plan services.

This Demonstration includes all current Medicare, Medicaid State Plan, and Medicaid HCBS waiver services. This constitutes a comprehensive benefit package; there are no other supplemental benefits.

Individuals who relocate to the community and subsequently have a non-NH LOC as established by the LTCFS will have a benefit package including all current

Medicare and Medicaid State Plan services, and any HCBS provided in-lieu-of State Plan services. This non-NH LOC benefit package is limited by the need to establish a NH LOC as functional eligibility for a complete set of HCBS waiver services.

c. Flexible Benefits – ICOs will have discretion to use the capitated payment to offer flexible benefits, as specified in the member's Individualized Care Plan, as appropriate to address the member's needs.

d. Excluded Services – There are no excluded services in this demonstration. All Medicare, Medicaid State Plan, and Medicaid HCBS Waiver services will be a part of the ICO benefit package and included in the capitated payments to ICOs.

e. Hospice Services – Hospice services will be included in the demonstration package and provided via managed care. The ICO will receive a capitation payment (the methodology is discussed in Appendix 6) and will remain responsible for coordinating and paying for the enrollee's care, including paying for hospice services.

   The three-way contract will include requirements for care planning and managing hospice referrals for individuals potentially meeting hospice criteria. These requirements will include end-of-life expertise participating on the IDT when an individual receives a terminal diagnosis with a prognosis of less than six months. The end-of-life expert will provide input as the enrollee and his/her IDT discuss options including hospice services via a hospice organization, other palliative care options, and continuing to pursue treatment.

   Guidance for ICOs, NHs, and hospice providers in developing contracts and agreements delineating roles and responsibilities in care coordination for enrollees who chose to receive hospice services will be developed. Some requirements may be incorporated in the three-way contract, while other guidance may be provided via separate documents or technical assistance.

f. Continuity of Care

   i. The ICO must participate in the enrollee's next scheduled MDS assessment within 90 days of an individual's enrollment in the ICO. In addition, if the enrollee's next scheduled MDS assessment is more than 30 days after the date of the individual's enrollment, the ICO must also review the current MDS assessment conducted by the nursing home within 30 days of an individual's enrollment.

ii. The ICO must create an initial care plan based on the most recent MDS assessment and resulting nursing home plan of care within 30 days of an individual's enrollment, whether that is based on an MDS assessment in which the ICO participated, or the ICO's review of the nursing home's assessment. The initial care plan is to include authorization of all current services and maintain the nursing home's plan of care unless:

    1. The enrollee and nursing home IDT members agree otherwise, or

    2. The ICO's review identifies an unmet need or a need not sufficiently served by the existing plan of care and modifies the initial care plan to address the need, and the enrollee agrees to the change.

iii. The ICO must create an Individualized Care Plan (ICP) building on the MDS assessment in which its IDT staff participated, as described in Section IV of this Appendix above, within 90 days of the individual's enrollment in the ICO.

iv. ICOs must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

    1. a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or

    2. Until the ICO participates in an MDS assessment and creates an Individualized Care Plan, whichever is longer.

v. During the time period set forth in Appendix 7, **Section V.d. iv.**, the ICO will maintain the Enrollee's current providers at their current provider rates and honor prior authorizations issued by Wisconsin Medicaid, its contracted managed care entities, and Medicare. As described in Section V.g.ii, provider rates may only change during this continuity of care period if mutually agreed in the provider contract and if access to the provider is maintained.

vi. If, as a result of the initial review of the MDS assessment or participating in the next MDS assessment, the ICO proposes modifications to the Enrollee's prior authorized services, the ICO must provide written notification about and an opportunity to appeal the proposed modifications

no less than 10 days prior to implementation of the Enrollee's ICP. The Enrollee shall be entitled to all appeal rights, including aid pending appeal, if applicable.

g. Out of Network Reimbursement Rules

i. In an urgent or emergency situation, ICOs must reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies.

ii. ICOs are also required to participate in the Enrollee's MDS assessment and develop an ICP to meet the Enrollee's needs within the first 90 days of enrollment as described in Appendix 7 Section IV.f. Until that assessment and ICP has been completed, the ICO must continue to provide access to the same services and providers at the same levels and rates of payment as individuals were receiving prior to entering the ICO.

1. If the ICO and provider mutually agree in a provider contract on a different rate earlier and the same level of access for the enrollee is maintained throughout the continuity of care period, then the ICO shall provide access at the new rate of payment as mutually agreed.

iii. Beyond this 90-day period, under certain circumstances to be defined in the three-way contract, ICOs will be required to offer single-case out-of-network agreements to providers who are currently serving Enrollees and are willing to continue serving them at the Plan's in-network payment rate, but who are not willing to accept new patients or enroll in the Plan's network.

iv. ICOs will also be required, under certain circumstances to be defined in the three-way contract, to offer single-case out-of-network agreements to providers when necessary to support an enrollee's relocation from a nursing facility to a community setting.

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. CMS' Special Needs Plan (SNP) MOC elements and scoring criteria will be incorporated into the ICO certification process. The Demonstration Plan MOC approval portion of the certification 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 below and clarified as needed in additional certification materials or contract requirements.

(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: CMS and DHS will agree upon relevant scoring factors derived from SNP MOC scoring for each element and include specific score factors and criteria in additional certification materials. Certain elements will be scored on criteria specific to the demonstration. The target population must be the demonstration's target population. Assessments must include the MDS for nursing home residents and include the LTCFS and other comprehensive assessments for individuals who relocate, and the portions of the MOC describing communication and use of assessments may be scored on criteria specific to coordination and care planning in a nursing home setting. Scoring criteria for the section regarding vulnerable subpopulations may also be revised to reflect triaging care coordination efforts within the demonstration population. Criteria will also reflect that supplementation of the already comprehensive benefit package is not expected. DHS and CMS will modify or clarify the demonstration-specific scoring criteria to reflect these

demonstration-specific issues and provide the criteria and any additional necessary instruction or clarification to applicants in the certification process.

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 our 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 integrated demonstration 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 integrated demonstration 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 integrated demonstration MOC requirement for one (1) year.

Participating Plans will be permitted to cure problems with their MOC submissions after their initial submissions. Participating Plans with MOCs scoring below 85 percent on the demonstration-specific scoring criteria will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, MOCs that do not meet the integrated standards for approval will not be eligible for certification 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 shall be entitled to file internal grievances directly with the ICO. Each ICO must track and resolve its grievances, or if appropriate, re-route grievances to the coverage decision or appeals processes.

IX. Appeals - Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

i. Appeal time frames - Individuals, their authorized representatives and providers will have 60 days to file an appeal related to coverage. This matches the current 60-day time-frame for requesting an appeal related to benefits under Medicare, and matches the current 60-day time-frame for requesting an initial appeal related to benefits under Medicaid.

ii. Appeal levels –

1. Initial appeals will be filed with the ICO.

2. Second level appeals to an Administrative Law Judge (ALJ) in a State Fair Hearing: ALJs are to rule on coverage regardless of the traditional system in which the benefit would originate. ALJs already make Medicaid coverage decisions, and in most instances the Medicaid benefit is as generous in coverage rules as Medicare; however, ALJs will consider for Wisconsin Integrated Demonstration members whether Medicare would cover the service if Medicaid would not. Although Medicaid is payer of last resort in the FFS system, ALJs need not determine whether Medicare would have been the primary payer in the FFS system, only whether the service is covered.

3. Subsequent Appeals- Split Medicare and Medicaid Processes: If the decision at the State Fair Hearing is favorable to the beneficiary, the decision of the ALJ is final. If the decision is not favorable to the beneficiary or is only partially favorable, the next steps depend on whether the service could potentially have been covered by Medicare in the FFS system.

a. Medicare Appeals:

i. If the decision at the State Fair Hearing is not favorable to the beneficiary and

the service or item may have been covered by Medicare in the FFS system, the ALJ will automatically forward the appeal to Medicare's Independent Review Entity (IRE).

ii. If the decision of the IRE is not favorable, the beneficiary may choose to appeal to a federal ALJ

iii. If the decision of the federal ALJ is not favorable, the beneficiary may choose to appeal to the Medicare Advisory Council (MAC). If the MAC decision is not favorable to the beneficiary, the beneficiary may then appeal via civil action in federal court.

b. Medicaid Appeals: If the decision at the State Fair Hearing is not favorable to the beneficiary, and the service or item would only be covered in Medicaid, the beneficiary may appeal via a civil action in state or federal court.

iii. Use of an independent medical panel: DHS will contract with an independent entity to provide a medical review panel for consultation at the first and/or second level of appeals. The medical review panel will be contracted through an entity certified to review insurance claims in Wisconsin, and will be available to provide independent medical expertise in both the ICO's review of internal appeals and the ALJ's review of state fair hearing cases.

iv. No amount in controversy shall apply in the integrated appeals process. Access to this integrated process will not be restricted based on the monetary value of the coverage challenged.

v. Flexibility in appeals process: Beneficiaries may choose to pursue a State Fair Hearing either instead of or concurrently with initial appeal to the ICO.

vi. Appeal resolution time frames - Except where existing fair hearing or court timelines dictate otherwise, appeals must be resolved within 30 days

of their submission for standard appeals and within 72 hours of their submission for expedited appeals. Exceptions are described below for each level of appeal. This excludes Part D appeals, which will be resolved in accordance with existing rules.

1. First level appeals: Appeals must be resolved within 30 days of their submission for standard appeals and within 72 hours of their submission for expedited appeals. The 30 day timeframe may be extended by up to 14 additional calendar days if the enrollee requests the extension or the ICO justifies the need for additional information, documents how the delay is in the interest of the enrollee, and notifies the enrollee. The 72 hour expedited timeframe may only be extended up to 14 additional calendar days upon request of the enrollee.

2. Second level State Fair Hearing appeals: ALJ decisions are currently required within 90 days of the day a request for a hearing is filed. The State will consider the feasibility of speeding up this timeframe, but unless or until then, the 90 day timeframe will apply at the third level of appeals.

3. Subsequent Appeals: Appeals will be resolved according to the timeframes of the IRE, MAC, and/or court, according to each entity's schedule or requirements for scheduling such cases in the traditional appeals systems.

vii. Alternative traditional appeals processes: Beneficiaries may choose to pursue a standard Medicaid or Medicare managed care appeals process instead of the integrated process outlined above. The beneficiary must choose one such route and may not pursue both. In either traditional appeal process, all existing timelines for filing of and decisions on appeals shall apply according to the process chosen.

viii. Continuation of Benefits Pending an Appeal -

1. ICOs must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal ICO appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that ICOs must continue to pay providers for providing such services pending an

internal ICO appeal. This right to aid pending an appeal currently exists in Medicaid, but is generally not available in Medicare.

2. For all appeals the right to aid pending an appeal will continue so long as all timely filing deadlines are met. This is consistent with current Wisconsin Medicaid policy, and will apply to all benefits in Wisconsin Integrated Demonstration, including those for which Medicare would be the primary payer in FFS.

3. The ICO may seek to recover costs incurred for services provided while an appeal is pending from the beneficiary if the appeal is decided in favor of the ICO.

ix. Integrated Notice - ICO Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single notice.

X. Participating Plan Marketing, Outreach, and Education Activity

As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2013, CMS Medicare Marketing Guidelines do not apply to communication by State governments and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials and the State will consult with CMS on the development of the materials.

a. Marketing and Enrollee Communication Standards for Participating Plans – Participating Plans will be subject to rules governing their marketing and Enrollee communications as specified under:

i. Wisconsin Integrated Demonstration Marketing Requirements in this MOU and the three-way contract, which incorporate the applicable and relevant portions of section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., and

ii. Regulations and CMS guidance on Part D marketing, specifically including §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and Chapter 3 of the Prescription Drug Benefit Manual. The below MOU provisions specify how the Part D marketing regulations and CMS guidance are incorporated into overall Wisconsin Integrated Demonstration Marketing Requirements

b. Definition of Marketing Materials – Marketing materials are as defined in 42 CFR §422.2260 and §423.2260.

c. Review and Approval of Marketing and Enrollee Communications – Participating Plans must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and the State require to be prospectively reviewed. Participating Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR §422.2262(b) and §423.2262(b) and as jointly agreed by CMS and the State and specified in the three-way contract, and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and the State may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Participating Plans must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS Health Plan Management System Marketing Module.

    i. The timelines for review specified in 42 CFR §422.2262 and §423.2262 shall apply, unless the CMS and the State include other timelines in their agreement to defer to one or the other party for review.

    ii. The criteria for review shall be based on 1851(h) of the Social Security Act and 42 CFR §422.2264 and §423.2264, except that ICOs shall not be required to notify the general public of enrollment periods as in 42 CFR §422.2264(b) and §423.2264(b). This is not necessary as the demonstration does not offer specific open enrollment periods as in Medicare Advantage and Part D, but rather targets a specific subset of beneficiaries who may change plans at any time effective the following month.

        1. The State shall publish information on enrollment criteria and timelines on its website, make information available via Aging and Disability Resource Centers (ADRCs), and provide information directly to beneficiaries eligible for enrollment, and this shall be considered sufficient publication of enrollment information under federal regulations for purposes of this demonstration.

    iii. The deemed approval provisions of section 1851(h) of the Social Security Act and 42 CFR §422.2266 and §423.2266 shall apply.

d. Permissible Start Date for Participating Plan Marketing Activity and Restrictions on Marketing Activity in Nursing Homes – Participating Plans may begin marketing activity no earlier than 90 days prior to the effective date of enrollment for the contract year , except that certified ICOs may participate in any forums or meetings established jointly by DHS for enrollee outreach and education purposes. Within 90 days of the contract year or during the contract year, the following restrictions and timelines for marketing in a participating nursing home apply:

i. When implementing the demonstration in a new county or a new nursing home, ICOs may not market to nursing home residents outside DHS-sponsored forums before DHS has identified the initial set of individuals for passive enrollment.

ii. After DHS has identified the initial set of residents for passive enrollment, ICOs may market to beneficiaries identified for passive enrollment in the newly participating nursing home. Marketing in the nursing home is subject to the following restrictions, which are considered to comply with requirements in 42 CFR §422.2268 and §423.2268:

1. ICOs may make marketing materials available in the nursing home's common areas.

2. Nursing home staff may provide marketing materials to beneficiaries identified for passive enrollment.

3. ICOs may conduct additional question and answer sessions in the nursing home's common areas.

4. ICOs may conduct meetings with individuals or their representatives *only as requested by the individual or his/her representative* (if the representative makes enrollment decisions for the individual, such as a guardian).

a. If a passively enrolled beneficiary has not opted out 45 days after receiving the official enrollment notification letter, ICOs may contact beneficiaries for the purposes of beginning transitional care planning activities. This shall not be considered a prohibited marketing practice.

5. Participating nursing homes may provide or distribute marketing or other beneficiary materials without violating the requirements cited above with regard to displaying materials for all plans with which they contract, so long as they provide or distribute materials for all plans with which they contract for *Wisconsin Integrated Demonstration*.

    a. If a nursing home contracts with more than one Wisconsin Integrated Demonstration ICO, then the nursing home must make available marketing or other beneficiary materials from each ICO offering Wisconsin Integrated Demonstration in that facility.

    b. Provision of Wisconsin Integrated Demonstration marketing or other beneficiary materials to beneficiaries identified for passive enrollment in the demonstration will not automatically require provision of marketing materials for other types of plans, such as I-SNPs or other Medicaid programs, because it is the Wisconsin Integrated Demonstration into which such individuals would be passively enrolled.

6. ICOs may provide marketing materials in nursing homes that are targeted to voluntarily eligible enrollees, but may not directly contact such individuals unsolicited under any circumstances.

e. Other Prohibited Marketing Practices – The prohibited marketing practices described in 1851(h) of the Social Security Act and 42 CFR §422.2268 and §423.2268 shall be prohibited for Wisconsin Integrated Demonstration ICOs, with the following clarifications:

    i. Restrictions on marketing through providers or in health care settings shall be applied only as described in Appendix 7 Section X.d. of this MOU.

    ii. Plan names and other marketing or beneficiary materials that suggest the plan is not available to all beneficiaries shall be allowable so long as restrictions described or implied accurately reflect Wisconsin Integrated Demonstration eligibility criteria as described in this MOU.

f. Marketing Resources and Representatives –

i. The requirements in 42 CFR §422.2272 and §423.2272 to allocate marketing resources to disabled beneficiaries as well as those 65 and older shall not prohibit ICOs from marketing strictly to the primary-elderly nursing home population that is the target of this demonstration. Within that population, ICOs shall market to both disabled and elderly beneficiaries, acknowledging that most nursing home residents are elderly.

ii. Other requirements of 42 CFR §422.2272, §422.2274, §423.2272, and§423.2274 shall be enforced as applicable. It is not expected that ICOs will employ agents or brokers for enrollment into the demonstration, as most enrollees will be passively enrolled by the State and CMS. If ICOs do use agents or brokers, then the restrictions cited above and the provisions of section 1851(h)(7) of the Social Security Act regarding State collaboration to address inappropriate practice shall apply.

iii. The demonstration does not include employer-sponsored benefits; therefore, the provisions of 42 CFR §422.2276 and §423.2276 regarding Employer Group Retiree marketing are not applicable.

g. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, Participating Plans will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under Section 1851(h) of the Social Security Act; 42 CFR §422.111 as applicable and described below, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual, as applicable and described below, and Chapter 3 of the Prescription Drug Benefit Manual).

i. All required content, disclosable information, or other information to be provided described in 42 CFR §422.111, shall be specific to the Wisconsin Integrated Demonstration. Where content descriptions reference other statutes or regulations containing provisions that vary from this demonstration, the standard for the content of Wisconsin Integrated Demonstration materials shall be based on the MOU and three-way contract, not other references specific to Medicare Advantage plans. This includes, but is not limited to benefits descriptions, information specific to dual-eligible individuals, access information including provider network

and continuity of care information, grievance and appeal rights and processes, and quality information.

ii. Required marketing and enrollee communication materials shall be based on information or model documents agreed between CMS and the State and described in the three-way contract. All required documents shall be demonstration-specific and shall include:

1. An Evidence of Coverage (EOC) document that includes information about all covered benefits, described as an integrated benefit package that includes benefits from Medicare, Medicaid, and HCBS waiver programs.

2. 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 calendar year of the Demonstration. If there are no major changes in the Demonstration's covered benefits, and the Plan is not changing or offering other benefits not described in the demonstration's benefit package, then a simplified document stating this may be substituted for any ANOC based on standard Medicare requirements. Participating Plans will use a Demonstration-specific ANOC or simplified substitute document.

3. 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 premiums, cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.

4. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and supplemental benefits.

5. A comprehensive integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as Plan-covered supplemental benefits.

6. A single identification (ID) card for accessing all covered services under the Plan.

7. All Part D required notices, with the exception of the 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.

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

i. Provision of Marketing and Beneficiary Materials to ADRCs – ICOs must provide one electronic or one hard copy of marketing or outreach materials to ADRCs when the materials are developed and when changes are approved (or not disapproved) by CMS and the State. If a hard copy is provided, additional copies must be furnished to the resource center upon request.

XI. Administration and Oversight

a. Oversight Framework

Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require Participating Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. Participating Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the Plan and the third-party levels in the delivery of Plan benefits, including prescription drugs, medical care, and long term services and supports. In addition, all Part D requirements and Medicare Advantage requirements as specified in the three-way contract regarding oversight, monitoring, and program integrity will be applied to Demonstration Plans by CMS in the same way they are currently applied for PDP sponsors and Medicare Advantage organizations. CMS and the State will align oversight, monitoring, and reporting in the Demonstration with regulatory oversight of nursing homes to the extent practicable.

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, except in emergency or urgent situations as described in (e) below.

b. The Contract Management Team

1. Structure- The Contract Management Team will include representatives from CMS and the State Medicaid agency, authorized and empowered to represent CMS and the Medicaid Agency about all aspects of the three-way contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO), and a representative from federal Survey & Certification staff. The precise makeup of each team will vary by state, and will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term supports and services.

2. Reporting - Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes will be detailed in the three-way contract.[10]
    1. Quality (including HEDIS); core measures will be articulated in the MOU
    2. Rebalancing from Institutional to HCBS Settings
    3. Utilization
    4. Encounter Reporting

[10] Reporting requirements are an issue that may require further discussion in MOU finalization and/or three-way contract processes.

5. Enrollee Satisfaction (including CAHPS)
6. Complaints and Appeals
7. Enrollment/Disenrollment Rates
8. Part C and Part D Reporting Requirements, as negotiated and applicable

c. **Day-to-Day Oversight and Coordination –** The Contract Management Team will be responsible for day-to-day monitoring of each contractor. These responsibilities include, but are not limited to:

- 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 contractor;
- Receipt and response to complaints;
- Regular meetings with each contractor;
- Coordination of requests for assistance from contractors, and assignment of appropriate State and CMS staff to provide technical assistance;
- Coordinate review of marketing materials and procedures;
- Coordinate review of grievance and appeals data, procedures, and materials; and
- Review reports from the Ombudsman.

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 Part D activities and in any Medicare Advantage-based activities specified in these three-way contracts. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State and Contract Management Team will be informed about these activities and copied on notices, but will not take an active part in these ongoing projects or activities.

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

f. **ICO Call Center Requirement -** DHS and CMS will monitor Plan compliance with ICO call center requirements. Call center requirements shall include Medicare Advantage requirements as applicable and described in three-way contracts, and the following elements:

1. Participating Plans shall operate a toll-free Enrollee services telephone line a minimum of twelve hours per day, seven days per week. Use of alternate technologies such as voicemail on weekends and/or holidays shall be permitted as detailed in contracts.

2. Operators must be available in sufficient numbers to support Enrollees. Specific performance standards will be detailed in contracts.

3. Oral interpretation services must be available free-of-charge to Enrollees in all non-English languages spoken by Enrollees.

4. TTY services or comparable services must be available for the Deaf or hard of hearing.

5. Plans must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:

    a. The identity, locations, qualifications, and availability of providers;

    b. Enrollees' rights and responsibilities;

    c. The procedures available to an Enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials);

d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;

e. Information on all Participating Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and

f. The procedures for an Enrollee to change Plans or to opt out of the Demonstration.

g. Data System Specifications, Reporting Requirements, and Interoperability - The Contract Monitoring Team shall oversee compliance with data system and reporting requirements as established in the three-way contract. Requirements to be established include:

1. Data system description and architecture and performance requirements
2. Current information system upgrades and development plans and resource commitments necessary for implementation
3. Consolidated reporting requirements
4. Encounter reporting
5. Reporting data for evaluation and program integrity
6. Data Exchange among CMS, State of Wisconsin Providers and Contractors, and Health Insurance Exchanges (2014)

h. Unified Quality Metrics and Reporting

Participating Plans and other qualified entities will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report HEDIS, HOS and CAHPS data, as well as measures related to long term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional demonstration specific, nursing home focused measures agreed by the State and CMS and documented in the 3-way contract. The State will specify nursing home focused measures in the contract based on a nursing home quality measurement project currently underway in Wisconsin. All existing Part D metrics will be collected as well. CMS and the State will utilize a subset of these reported quality

metrics for the purpose of assessing Plan performance and outcomes and to allow quality to be evaluated and compared with other Plans in the model. The State will supplement quality reporting requirements with additional State-specific measures. A preliminary combined set of core metrics is described below in Figure 7-1 and will be further specified in the three-way contract. 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.

The State will add additional measures from a nursing home quality measurement project currently underway, with the goal of comparing participating and non-participating nursing homes. The measures from that project that will be applied to the demonstration will be specified in the three-way contracts.

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

Figure 7-1: Core Quality Measures under the Demonstration

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

Measure	Description	Measure Steward/Data Source	CMS Core Measure
Screening for Clinical Depression and Follow-up Care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X
SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/ HEDIS, with any modifications necessary for unique demonstration Model of Care (MOC)	X
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ HEDIS, with any modifications appropriate to an integrated benefit package	X
Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions	NCQA/HEDIS	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure
	Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions		
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey.	AHRQ/CAHPS	X
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data	X
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data	X
Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X
Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.	IRE	X
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)	X
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan.	CMS CTM data	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure
	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).		
Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X
Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan annually.	CMS Medicare Beneficiary Database Suite of Systems	X
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure
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
Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X
Access to Care	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS	
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 members with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X
Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure	X
Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure	X
Discharge Follow-up	Percent of members with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X
Self-direction	Percent of care coordinators that have undergone State-based training for supporting	CMS/State defined process measure	X

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

Measure	Description	Measure Steward/Data Source	CMS Core Measure
	(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.		
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan annually.	CMS	X
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS	X
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	X
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 ―badll (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 ―badll (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

Measure	Description	Measure Steward/Data Source	CMS Core Measure
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
Chronic Obstructive Pulmonary Disease (PQI 5)	Assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	AHRQ	
Congestive Heart Failure Admission Rate (PQI 8)	Percent of county population with an admission for CHF.	AHRQ	
Transition Record with Specified Elements Received by Discharged Patients	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other sites of care, or their caregiver(s), who received a transition record at the time of discharge including, at a minimum, all of the specified elements.	AMA-PCPI	
Timely Transmission of Transition Record	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X
Annual Monitoring for Patients on Persistent Medications	Percent of members 18 years and older who received at least 180-day supply of medication therapy for the selected therapeutic agent and who received annual monitoring for the therapeutic agent.	NCQA/HEDIS	
Use of Appropriate Medications for People with Asthma	Percent of members who were identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the year.	NCQA/HEDIS	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Percentage of adults 18-64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA/HEDIS	
Ischemic vascular disease (IVD): blood pressure	The percentage of patients 18 years of age and older who were discharged alive with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) during the measurement year or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had BP reported as under control <140/90.	NCQA/HEDIS	
Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	Percentage of members 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40, who were prescribed ACE inihibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge.	AMA-PCPI	

Measure	Description	Measure Steward/Data Source	CMS Core Measure
Evaluation of Left Ventricular Systolic Function	Percent of heart failure patients with documentation in the hospital record that left ventricular systolic function was evaluated before arrival, during hospitalization or is planned for after discharge.	CMS	
Pain Assessment Conducted	Percent of home health episodes where the member had any pain at start of episode and was assessed using a standardized pain assessment tool.	University of Colorado	
Comprehensive Diabetes Care	Percent of individuals 18-75 with diabetes (type 1 and type 2) who had each of the following: - HbA1c poor control (>9.0%) -HbA1c control (<8.0%) - HbA1c control (<7.0%) * -Eye exam (retinal) performed - LDL-C screening -LDL-C control (<100 mg/dL) - Medical attention for nephropathy -BP control (<140/90 mm Hg) -Smoking status and cessation advice or treatment	NCQA/HEDIS	
Ability to use Health Information Technology to Perform Care Management at Point of Care	Documents the extent to which a provider uses an electronic medical record.	CMS	
Mental Health Utilization	Number and percentage of members receiving mental health services during the measurement year.	NCQA/HEDIS	
Unhealthy Alcohol Use: Screening and Brief Counseling	Screening and brief counseling for substance use.	AMA-PCI	
HCAHPS	27 item survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	AHRQ/CAHPS	
Tobacco Use Assessment and Tobacco Cessation Intervention	Percent of patients who were queried about tobacco use one or more times during the two-year measurement period (received cessation intervention during measurement period).	AMA-PCPI	
Cervical Cancer Screening	Percent of women 21-64 who receive one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS	
Adult Weight Screening and Follow-up	Percentage of patients ages 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented.	NCQA/HEDIS	

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

XII. Evaluation

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

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

The evaluator will design a State-specific evaluation plan for the Wisconsin Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. Alternatively, if an appropriate comparison group cannot be identified for Wisconsin, the evaluator will use a pre-post within-State design. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Wisconsin-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Wisconsin is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Wisconsin and Participating Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the three-way contract. Wisconsin will also 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.

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

- Beneficiary-level data identifying beneficiaries eligible and enrolled in the demonstration:
    - Medicare Beneficiary Claim Account Number (HICN)
    - MSIS number
    - Social Security Number
    - CMS Beneficiary Link Key
    - Person First and Last Name, Birthdate, and Zipcode
    - Eligibility identification flag - Coded 0 if not identified as eligible for the demonstration, 1 if identified by administrative criteria, and 2 if by non-administrative criteria (e.g. BMI, smoking)
    - Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
    - Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled, and zero if not.
- Summary level data for the State Data Reporting System, including but not limited to:
    - The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g. individuals with other insurance)
    - 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

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

Appendix X: Using the Resource Allocation Decision Method (RAD) in Wisconsin's Integrated Demonstration

What is the Resource Allocation Decision Method?

The Resource Allocation Decision (RAD) method is used in Wisconsin's Integrated Demonstration to determine the most effective services and supports to help members achieve their own personal outcomes. It is also used in Wisconsin's other managed long term care programs. The RAD is a series of questions designed to help the interdisciplinary team (IDT), including the member, identify the specific goals members have for their lives. This question and answer process is designed to determine the most effective services and supports for each individual member.

Each integrated care organization (ICO) is required to have policies and procedures for their interdisciplinary care management teams to use when authorizing services. The Department of Health Services (DHS) must approve the ICO's service authorization policies. The RAD method as developed and disseminated by DHS, when used by the team, including the member, will be approved by DHS as a service authorization policy. In the integrated demonstration, these policies and procedures must include using the national and local coverage determinations as a source of policy guidelines describing covered services.

The RAD Method

1. What is the need, goal, or problem?
2. Does it relate to the member's assessment, service plan and desired outcomes?
3. How could the need or goal be met?
4. Are there policy guidelines to guide the choice of option?
5. Which option does the member (and/or family) prefer?
6. Which option is the most effective and cost-effective in meeting the desired outcome?
7. Explain, Dialogue, Negotiate

Refer to the "Wisconsin Integrated Demonstration Resource Allocation Decision Method" on below for the seven step process and more details.

Who uses the RAD Method?

The interdisciplinary team uses the RAD to aid in the decision making process. A member has the right to include anyone else he or she wants to have involved, which could be a guardian, a family member or friend, or a professional ombuds or advocate. In the integrated demonstration, the team consists of the member and at least a care coordination point person. For nursing home residents, nursing home staff may also be involved. A registered nurse from either the nursing home or the ICO will be included, and either the member's primary care doctor or the nursing home's medical director will be consulted, in all decisions about the services to be provided in the nursing home. Other professionals such as an occupational or physical therapist, or mental health specialist, may be involved, depending on what is most appropriate for each member.

When is the RAD Method used?

• Creating the care plan. For nursing home residents, this is one integrated care plan jointly developed by the nursing home and ICO.
• On-going care planning
• When a member makes a request for additional services or supports

How does the RAD Method help determine services?

The RAD method is a way for the team, including the member, to decide the most effective services and supports to help the member achieve his/her outcomes. All decisions should be based on the individual's outcomes as prioritized and identified during the initial comprehensive assessment and after that, on an ongoing basis. The member's outcomes represent what is valued or important to him or her, or are things he or she wishes were different in his or her life. For example, one person's outcome might be being healthy enough to enjoy visits with her grandchildren, while another person might want to be able to be independent enough to live in his own apartment. The team will discuss the specific things the member wants to have in his or her life.

After the member's outcomes have been identified, the team will use the RAD method to identify and discuss the most effective way to help the member achieve those outcomes, at a reasonable cost.

"What's the most cost-effective way to support the individual's outcomes?"

1. All decisions should be based on the individual's outcomes.
   - This requires knowing the member, his or her preferences, values, and history. This also requires completion of a comprehensive social and health assessment.
   - Decisions should not be about "stuff". Do not focus only on things or services. When a member requests a service or support, ask "why" until you can link it to an outcome.
2. What are the EFFECTIVE options for achieving the member's outcomes?
   - Effective means it works to support the outcomes.
   - Options can include non-traditional, alternative or complementary approaches/therapies.
   - Remain flexible and creative when brainstorming ideas.
3. Among the effective options, which is/are the most cost-effective?
   - Cost-effective means it does so at a reasonable cost.
   - Cost-effective does not mean "least expensive".

Why is the RAD Method used?

In the integrated demonstration, services are specific to the member's personal outcomes. Each care plan is unique. The RAD assists in making service decisions that are specific to each member. The decision making process is the same but the decisions are not necessarily the same. Services and supports are based on the needs and outcomes for each member's unique

circumstances. The RAD method is a tool to support the team in putting effective services in place to support efforts to achieve the member's outcomes.

What if the member disagrees?

Reasonable people can disagree. The member may not always agree with the rest of the team about which service will be effective or cost-effective. Use the RAD method to talk through the options and preferences.

The integrated demonstration provides members with multiple pathways or options to file a grievance or appeal. This is the member's choice and right. A grievance or appeal is not a bad thing – it is a way for the member to say he or she is unhappy with something. This is an opportunity to work with the member to discover the most effective services and supports to meet the member's outcomes.

If a member wants help in filing a grievance or appeal, each care coordinator should be ready to explain the process and provide the member with the name of the ICO staff designated to help members with grievances and appeals. The member may also contact a professional ombuds or advocate. Additional information for the member regarding advocates and the appeals and grievance process are listed in the Member Handbook and in the Evidence of Coverage booklet.

RESOURCE ALLOCATION DECISION METHOD

1. **What is the need, goal, or problem?**
    - The member and team staff together identifies the core issue. To do so, keep asking, **"Why?"**
    - Whose problem is it? Does the member see it as a problem, or do (some) staff?
    - If the member/family is asking for an item or service, explore the reasons for the request.
2. **Does it relate to the person's assessment, service plan and desired outcomes?**
    - "Desired outcomes" are those in demonstration's mission and the person's assessment and service plan.
    - Is it essential to the person's health or safety? (What would happen if the need weren't met?)
    - How does it relate to ADLs or IADLs, independence and other desired outcomes in the plan?
    - Whose responsibility is it to address this particular need or problem?
3. **How could the need be met?**
    - What's been tried in the past? How do people usually address similar needs?
    - How could the member help solve this need/problem? What ideas does s/he have? Could adaptations in people, environment, or equipment help member meet this need? Can s/he afford to pay for this, or share cost if appropriate?
    - What informal resources (family, friends, volunteers) might be able to help?

- What other community resources (e.g., thrift stores, senior center, organizations) could be sought?
- What options could ICO consider (e.g., loaner program, rental vs. purchase, incremental goals)?

4. **Are there policy guidelines to guide the choice of option?**
   - If yes, those should be followed.
   - This includes Medicare national and local coverage determinations.
5. **Which option does the member (and/or family) prefer?**
6. **Which option(s) is/ are the most effective and cost-effective in meeting the desired outcome(s)?**
   - "Effective" means it works to achieve a desired outcome. Consider both short-term and long-term outcomes.
   - "Cost effective" means "effectively achieving a desired outcome (meeting a need) at reasonable cost and effort."
   - "Reasonable" alternatives are those that:
     - Would probably solve the problem, i.e., are effective in meeting the desired outcome for peers (persons with similar needs).
     - Would not have significant negative impact on desired outcomes.
   - Note that "cost effective" is always tied to outcomes, and that it does not always mean "least expensive" or "inexpensive."
   - How will we measure success/ outcomes in order to gauge cost-efficiency?
   - Is member committed to using the suggested service/product?
7. **Explain, Dialogue, Negotiate** Consumer can appeal the ICO's decision.

Appendix Y: Virtual PACE Enrollee Bill of Rights

Written Policies and Implementation Procedures

The Integrated Care Organization (ICO) must written policies and implement procedures to ensure that the participants, his or her representative, if any, and staff understand these rights.

Explanation of Rights

The ICO must inform participants upon enrollment, in writing, of his or her rights and responsibilities, and all rules and regulations governing participation.

Protection of Rights

The ICO must protect and provide for the exercise of participant's rights.

Those rights will include at a minimum:

1. Respect and nondiscrimination

Each participant has the right to considerate, respectful care from all ICO employees and contractors at all times and under all circumstances.

Each participant has the right not to be discriminated against in the delivery of required Virtual PACE services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, or source of payment.

Specifically, each participant has the right to the following:

a) To receive comprehensive health care in a safe and clean environment and in an accessible manner
b) To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care and be provided humane care
c) Not to be required to perform services for the ICO.
d) To have reasonable access to a telephone
e) To be free from harm, including physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the participants medical symptoms
f) To be encouraged and assisted to exercise rights as the participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights
g) To be encouraged and assisted to recommend changes in policies and services to ICO staff.

2. Information Disclosure.

Each participant has the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions.

Specifically, each participant has the following rights:

a. To be fully informed in writing of the services available from the ICO, including identification of all services that are delivered through contract's, rather than furnished directly by the ICO at the following times:
    i. Before enrollment
    ii. At enrollment
    iii. When there are changes in services

b. To have the enrollment agreement, fully explained in a manner understood by the participant
c. To examine, or upon reasonable request, to be assisted to examine the results of the most recent review of the ICO conducted by CMS or the state administering agency and any plan of correction in effect .

3. Choice of Providers

Each participant has the right to a choice of health care providers, within the ICO network, that is sufficient to ensure access to appropriate high-quality health care. Specifically, each participant has the right to the following:

a. To choose his or her primary care physician and specialist from within the ICO network
b. To request that a qualified specialist for women's health services furnish routine or preventive women's health
c. To disenroll from the program at any time

4. Access to Emergency Services

Each participant has the right to access emergency health care services when and where the need arises without prior authorization by the ICO interdisciplinary team.

5. Participant in Treatment Decisions

Each participant has the right to participate in all decisions related to his or her treatment. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. Specifically, each participant has the following rights:

a. To have all treatment options explained in a culturally competent manner and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.
b. To have the ICO explain advance directives and to establish them, if the participant so desires
c. To be fully informed of his or her health and functional status by the multidisciplinary team.
d. To participate in the development and implementation of the plan of care
e. To request a reassessment by the multidisciplinary team.
f. To be given reasonable advance notice, in writing, or any transfer to another [treatment] setting and the justification for the transfer (that is, due to medical reasons or for the participant's welfare, or that of other participants). The ICO must document the justification in the participants [medical] record.

6. Confidentiality of Health Information

Each participant has the right to communicate with health care providers in confidence and to have the confidentiality of his or her information protected. Each participant also has the right to review and copy his or her own medical records and request amendments to those records. Specifically, each participant has the following rights:

a. To be assured of confidential treatment of all information contained in the health record, including information contained in an automated data bank.
b. To be assured that his or her written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it
c. To provide written consent that limits the degree of information and the persons to whom information may be given

7. Complaints and Appeals

Each participant has the right to a fair and efficient process for resolving differences with the ICO, including a rigorous system for internal review by the organization and an independent system of external review. Specifically, each participant has the following rights:

a. To be encouraged and assisted to voice complaints to ICO staff and outside representatives of his or her choice, free of any restraint, interference, coercion, discrimination, or reprisal by the ICO staff.
b. To appeal any treatment decision of the ICO, its employees, or contractors.