Second Extension of

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Minnesota

Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience

I. STATEMENT OF INITIATIVE

The purpose of this Initiative is to establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Minnesota (State) to extend the implementation the Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees or Beneficiaries). The Minnesota Senior Health Options program (MSHO) is one of the first integrated care initiatives for Medicare-Medicaid Beneficiaries, serving approximately 36,000 older adults through eight different health plans that contract with the State as Medicaid managed care organizations and with CMS as Medicare Advantage Special Needs Plans for Dual Eligibles (D-SNPs). Although the program has made great strides in integrating care for Medicare-Medicaid Beneficiaries, there are still many opportunities to more fully align Medicare and Medicaid within MSHO, to improve Beneficiary experiences and to address administrative efficiencies. (See Appendix 1 for definitions of terms and acronyms.)

As a highly integrated program, MSHO has been successful in improving the Beneficiary experience by increasing access to care, delivering person-centered care, and promoting independence in the community. This Demonstration will further strengthen program integration and improve the Beneficiary experience by testing opportunities to better align existing Medicaid and Medicare Advantage managed care programs. To that end, the Demonstration is designed to enhance integration of services for Medicare-Medicaid Beneficiaries in new provider payment models, work to clarify and simplify information and processes for Beneficiaries and their families related to Medicare and Medicaid coverage, better align oversight of MSHO Plans by the State and CMS, and improve administrative efficiencies for the MSHO Plans and government agencies that serve MSHO Enrollees. Specifically, the Demonstration's key objectives are:

- To enhance quality of care for Medicare-Medicaid Beneficiaries by improving coordination of services.
- To provide a more seamless experience for Medicare-Medicaid Beneficiaries, utilizing a simplified and unified set of program administration rules and materials.
- To allow CMS and the State to continue to work together to integrate Medicare and Medicaid policy and delivery of services, while operating within the context of the Medicare Advantage and Medicare Part D programs.
- To support State statutory goals of aligning programs for Medicare-Medicaid Beneficiaries with other State provider payment and delivery reforms to improve overall

system performance and care outcomes for Medicare-Medicaid Beneficiaries, including Minnesota's Health Care Homes and Integrated Care System Partnership projects.

- To identify ways to reduce administrative burdens and control costs for both the State and the Federal government.
- To test new and streamlined reporting requirements.
- To begin developing and testing new ways of measuring quality in integrated care programs.

This Demonstration includes the health plans in the MSHO program as of January 1, 2013, identified in Appendix 1, and any subset thereof should any plans terminate their participation in MSHO. These plans will continue to operate under separate contracts with the State (as Medicaid managed care organizations) and CMS (as D-SNPs). Their contracts with CMS will be amended to reflect the terms of this MOU.

The Demonstration began on September 13, 2013, and will be extended under this MOU to continue until December 31, 2020[1], unless terminated pursuant to section IV.L or continued pursuant to section IV.K of this Memorandum of Understanding (MOU). Individual provisions of this MOU, however, may take effect at later dates based on timing in the contracting cycles, requirements for additional approval, or other factors. MSHO Plans must continue to operate as D-SNPs in order to participate in this Demonstration, which requires the plans to comply with prevailing Medicare Advantage and SNP requirements, unless waived in this MOU, as well as Demonstration specific requirements. MSHO Plans must also maintain a MSHO contract with the State in order to continue to participate in this Demonstration.

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.

[1] A previous extension extended the MOU until December 31, 2018. Upon execution, this will represent the second extension for the State of Minnesota.

II. BACKGROUND ON INTEGRATED CARE IN MINNESOTA

Minnesota was originally selected as one of 15 states to receive a contract from CMS to design new approaches to better integrate care for Medicare-Medicaid eligible individuals. While Minnesota considered the Financial Alignment Initiative's Capitated Model initially, the State is proposing to use MSHO as the platform for the Demonstration, focusing on Medicare-Medicaid alignments within the current Medicare Advantage and State Medicaid contracting structures.

The MSHO program serves approximately 36,000 Medicare-Medicaid eligible individuals age 65 and over through eight different health plans. In addition, the State has embarked upon system-wide multi-payer payment and delivery reform.

Through the Demonstration, Medicare-Medicaid eligible individuals will continue to have access to the full range of Medicare and Medicaid services available in Minnesota. They will also have access to the innovative service delivery options being developed and implemented in the Minnesota health care system while maintaining the integration that already exists. The goal of the new service delivery innovations in Minnesota is to create improvement in the health care system that ultimately increases quality and lower costs. In addition, by improving administrative efficiencies, the State and CMS help strengthen the MSHO Plans' ability to continue to serve Medicare-Medicaid Beneficiaries.

The Demonstration allows CMS and the State the opportunity to test ways in which the SNP program and State Medicaid programs may better integrate the delivery of services for Beneficiaries. For example, Medicare requires that Medicare Advantage plans send letters to Beneficiaries stating when their skilled nursing facility benefits are exhausted. While this is necessary to communicate changes for Medicare beneficiaries, this communication may lead to more confusion for Medicare-Medicaid Beneficiaries whose services in the facility would continue to be covered under Medicaid. While a small change, modifying the notice to reflect continuing Medicaid coverage is an example of how this Demonstration might lessen beneficiary confusion.

III. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the agreement between CMS and the State regarding the principles under which the Demonstration will be implemented and operated. It also outlines the activities which CMS and the State agree to conduct in preparation for implementation of the initiative. Specific details regarding the initiative, as noted throughout this MOU, will be subject to additional approval by CMS and the State and, as necessary, amendment of existing contracts with CMS

and/or the State. Unless otherwise described in the body or Appendices of this MOU, all relevant Medicare Advantage and Medicaid managed care requirements will remain in place.

IV. DEMONSTRATION DESIGN / OPERATIONAL PLAN

A. DEMONSTRATION AUTHORITY

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 5. As a term and condition of the Demonstration, MSHO Plans included in this Demonstration will be required by CMS to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 CFR Parts 422 and 423; and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 5; and for waivers of sub-regulatory guidance other approved CMS documents.

Medicaid Authority: The Medicaid elements of the Demonstration shall operate according to applicable State of Minnesota laws, regulations, and waivers, as amended or modified, including but not limited to Minnesota Statutes § 256B.021, subdivision 4 (i), and applicable Federal laws, regulations, and waivers, as amended or modified, including but not limited to title XIX of the Social Security Act and 42 CFR Part 438 et seq., other applicable regulations, and applicable sub-regulatory guidance, as amended from time to time.

B. CONTRACTING PROCESS

1. **MSHO Plans** participating in the Demonstration will contract directly with CMS as currently required for participation in Medicare Parts C and D. MSHO Plans will also contract with the State to provide Medicaid benefits to Enrollees. Contracts with the State will be modified to explicitly incorporate specific parameters of this MOU as conditions of participation as a Minnesota MSHO Plan. MSHO Plan D-SNP contracts with CMS will also be modified or amended, as needed, and effective no earlier than January 1, 2014, to incorporate specific parameters of this MOU.

2. **Medicare Waiver Approval:** Any CMS approved Medicare waivers are 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 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.

C. ENROLLMENT

The Demonstration will involve individuals who are currently enrolled or choose to enroll in Minnesota Senior Health Options (MSHO). The Demonstration will test new mechanisms for improving the enrollment and disenrollment process, as described further in Appendix 4. Otherwise, the Demonstration will not fundamentally change the prevailing enrollment process for MSHO. The Demonstration does not include passive enrollment.

D. DELIVERY SYSTEMS AND BENEFITS

The Demonstration will not fundamentally change benefits packages, choice of providers and plans for Beneficiaries, or the ways in which the MSHO Plans contract with either the State and CMS. However, MSHO is an important vehicle for wider adoption of delivery system reforms throughout Minnesota. Building on provider contracting arrangements under MSHO and its current Medicaid Health Care Home benefit, the State will promote relationships between MSHO Plans and providers called Integrated Care System Partnerships (ICSPs). The goals of these ICSPs are to improve coordination between Medicare and Medicaid services and, ultimately, to help Beneficiaries remain in their homes or choice of community settings and improve health outcomes in all settings.

The State has developed a range of ICSP arrangements based on provider interest and capacity, as well as geographic and demographic factors. The State's MSHO contracts outline the following models:

- Model 1. Health Care Home-based Virtual Integrated Care System Partnerships (Virtual ICSPs). Minnesota created Health Care Homes (HCHs) to provide payments to primary care providers that would incent better coordination of the entire spectrum of care provided to an individual. Building on the current all-payer HCH requirements in Minnesota, under the Demonstration the State and MSHO Plans will identify options for increasing coordination among MSHO Plans and the plan care coordinators, contracted clinics, and practitioners certified as health care homes, as well as with other contracted providers.

- Model 2. HCH or HCH alternative based primary, acute, and/or long term care ICSPs. This model builds on the State's HCH approach to further integrate primary and long term care coordination and delivery. New contract requirements require each MSHO plan to submit proposals for ICSPs to the State for review and to implement new arrangements no later than January 2014. About 20 ICSP proposals are expected. The ICSPs will also allow plans to

strengthen and revise current primary care partnerships already existing within the MSHO Plans. The new contracting requirements tie provider performance to a range of financial metrics including pay for performance goals, performance pools, and total cost of care systems with risk/gain parameters. These arrangements facilitate the integration of HCH coordination provided by primary care providers with other all care coordination provided under the Medicaid acute and long term care and Medicare.

- Model 3. Integration of Physical and Behavioral Health Integrated Care System Partnerships. This model focuses on improving coordination and integration of physical health services with behavioral services. For individuals with coexisting physical and mental/chemical health service needs, these partnerships will allow for a more coordinated approach to addressing the Beneficiaries' comprehensive health care needs. For example, persons with chronic conditions and MH/CD diagnoses are more frequent users of hospital emergency services. This option allows further integration of Medicaid Mental Health Targeted Case Management Services with other care coordination required under Medicare and Medicaid including HCH, and/or soon to be Behavioral Health Homes (development of BHH as a Medicaid service is underway), in order to focus on reducing the need for emergency visits.

E. BENEFICIARY PROTECTIONS AND PARTICIPATION

1. **Network Adequacy:** The Demonstration will not fundamentally change either the State or Medicare Advantage methodology for determining provider network standards. However, under this Demonstration, CMS (or its designated contractor) will work with the State to conduct a new network review for all MSHO Plans. The review process will begin in 2014 and be applicable for a contract year no earlier than contract year 2015. As further discussed in Appendix 4, CMS will test new standards that utilize the prevailing Medicare Advantage methodology but are based on the Medicare-Medicaid population and will provide the State with an opportunity to participate in the review of network submissions.

2. **Beneficiary Protections from Cost Sharing:** The Demonstration will not add any new beneficiary cost sharing requirements. MSHO Plans will follow the Medicare Advantage and Part D bid process to determine Medicare capitation rates and any applicable premiums, but CMS and the State will support plan efforts to maintain zero premiums for MSHO, as described in Appendix 3.

3. **CMS and the State will ensure the continued protection of beneficiary rights during this Demonstration, while expanding enrollee access to beneficiary information.** CMS and the State will continue to ensure that MSHO Plans:

    a. Provide continuous beneficiary access to all medically necessary Medicare- and Medicaid-covered items and services.

b. Provide access and notice of the right to an integrated appeals and grievances process through an integrated notice of appeal rights.

c. Ensure provider compliance with all applicable beneficiary protections and laws, including but not limited to the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964, and promote compliance with the application of the *Olmstead* decision by helping MSHO Enrollees access home and community-based alternatives to institutional placement.

d. Ensure access to information and services that are culturally appropriate and meet language access requirements.

e. Provide for the privacy and security of medical records, as well as Enrollee access to these records.

F. INTEGRATED APPEALS AND GRIEVANCES

Prior to this Demonstration, CMS and the State collaborated to integrate elements of the appeals and grievance processes in MSHO. This Demonstration will add new features to simplify communications with Beneficiaries and their families. The simplification and alignment of communications with Beneficiaries is intended to improve their understanding of the Medicare and Medicaid programs and to simplify the process of accessing services to which they are entitled.

Under the Demonstration, the appeals process in MSHO will include:

1. **Integrated Notice:** The State will use a new simplified, integrated model notice for appeals explanations, developed and approved by CMS. The new notice will retain all essential information for Enrollees and be used, with modifications as needed, throughout the Demonstration.

2. **Appeal time frames:**
    a. Prior to January 1, 2018,Enrollees, their authorized representatives, and providers for Medicare service appeals will have 90 days to file an appeal related to denial, reduction, or termination of authorized Medicare benefit coverage. Enrollees, their providers, or their authorized representatives will have 90 days to file an MCO/SNP appeal related to the denial of services or payment or the reduction or termination of previously authorized Medicaid or Medicare/Medicaid hybrid benefit coverage. The 90-day period extends the typical Medicare period by 30 days to allow for additional flexibility for Beneficiaries and to align the Medicaid and Medicare timelines.

b. On and after January 1, 2018, all 90-day timeframes described in section F.2.a above will change to 60 days.

Unless otherwise described above or in Appendix 5, all relevant Medicare Advantage and Medicaid managed care requirements will remain in place. Part D appeals and grievances will continue to be managed under existing Part D rules, and non-Part D pharmacy appeals will be managed under the current State process including state fair hearings. CMS and the State will work to continue to coordinate grievances and appeals for pharmacy benefits.

G. ADMINISTRATION AND REPORTING

1. **Participating Plan Contract Management:** CMS and the State agree to designate representatives to serve on a CMS-State Contract Management Team which shall conduct MSHO contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency.

   Contract management activities shall include but not be limited to:
   - Reviewing reports of beneficiary complaints, reviewing compliance with applicable CMS and/or State Medicaid agency standards, and initiating programmatic changes as appropriate.
   - Reviewing and analyzing reports on MSHO Plans' network adequacy, including the Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
   - Reviewing input from stakeholders and the Minnesota Ombudsman for Managed Care on both plan-specific and systematic performance.
   - Responding to and investigating beneficiary complaints and quality of care issues.
   - Addressing issues or concerns that arise from changes in policy that may impact the Demonstration and/or cause misalignment of the Medicare and Medicaid programs that may harm Beneficiaries' access to care and services.

2. **Day-to-Day Participating Plan Monitoring:** CMS and the State will establish procedures for daily monitoring, as described in Appendix 4. Oversight shall generally be conducted in line with the following principles:

   - Oversight will be coordinated and subject to a unified set of requirements, and will build on areas of expertise and capacity of the State and CMS.

   - CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poorly

performing plans from the program, leveraging existing CMS tools, such as the Complaints Tracking Module, and existing State oversight and tracking tools.

3. **Consolidated Reporting Requirements:** MSHO Plans will continue to report quality measures and other data as required in their Medicare and Medicaid contracts, including HEDIS, HOS, and CAHPS data. All existing Part D metrics will be collected as well. MSHO Plans will continue to participate in Star quality rating systems. During the Demonstration, CMS and the State will test data-sharing to reduce survey burden on Beneficiaries and the need for duplicative data collection and reporting. See Appendix 4 for more detail.

H. 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 continue to conduct comprehensive performance and quality monitoring processes.

During the Demonstration, and unless otherwise identified in this MOU, MSHO Plans will be subject to the prevailing Medicare Advantage performance measurement and Part D requirements, public reporting systems and required quality initiatives, including Chronic Care Improvement Programs (CCIP), Quality Improvement Projects (QIP), and Medicaid External Quality Review Organization (EQRO) activities as well as all current Medicaid measurement and reporting systems. In addition, the State will test new quality measurement approaches that may include new measures, revisions to existing surveys, translating surveys into different languages to increase Enrollee response rates, and/or revised data sharing arrangements and analysis. New measures will be tested in conjunction with national consensus organizations and CMS. The measures are discussed further in Appendix 4.

J. EVALUATION

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 4, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on service utilization and program expenditures.

The evaluation will focus on the experiences of care for MSHO Enrollees, using both qualitative and quantitative methods. The data collection process will include focus groups

and key informant interviews, in addition to the ongoing collection of CAHPS, HEDIS, and HOS data. Key aspects and administrative features of the Demonstration 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 MSHO Plans will submit all data required for the monitoring and evaluation of this Demonstration. The State and MSHO Plans will submit both historical data relevant to the evaluation and reporting requirements, including but not limited to encounter data and data generated during the Demonstration period, and State submission of MSIS data from the years immediately preceding the Demonstration. CMS will provide a review of preliminary draft findings to the State and seek its input to assure accuracy of the final evaluation findings.

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: 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. Additionally, the terms of this MOU shall continue to apply to the State as it implements associated phase-out activities beyond the end of the Demonstration period.

1. **Limitations of MOU**: This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.

2. **Modification**: Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act including 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. Issues or concerns that arise from changes in policy that may impact the Demonstration and/or cause misalignment of the Medicare and Medicaid programs that may harm Beneficiaries' access to care and services would also be addressed through modifications to the MOU.

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

    a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provide a minimum of 90 days' advance notice to the other entity and 60 days' advance notice is given to Beneficiaries and the general public, as appropriate.

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

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

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

    Because this Demonstration is built on existing Medicaid or Medicare Advantage contracting rules, CMS and the State will each be required to ensure access to ongoing coverage as defined by their contracts.

4. **Demonstration phase-out:** Termination at the end of the Demonstration must comply with all notice and fair hearing requirements found in 42 CFR part 431, subpart E. If a Demonstration Enrollee requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR § 431.230.

M. SIGNATURES

This MOU extension is effective beginning TBD through the end of the Demonstration period [December 31, 2020].

In Witness Whereof, CMS and the State of Minnesota 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:

/Seema Verma/	September 29, 2018
Seema Verma	(Date)
Administrator	

State of Minnesota, Department of Human Services:

/Emily Johnson Piper/	August 6, 2018
Emily Johnson Piper	(Date)
Commissioner	

Appendix 1: Definitions

Action – 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MSHO Plan to act within the timeframes defined by Medicare Advantage/Part D and Medicaid contracts; or, 6) for a resident of a Rural Area with only one MSHO Plan, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.

Appeal – An oral or written request from the Enrollee, their provider, or the Enrollee's representative, acting on behalf of the Enrollee with the Enrollee's written consent, to the MSHO Plan for review of an Action.

Beneficiary – An individual eligible for and accessing both Medicare and Medicaid services.

CMS – The Centers for Medicare & Medicaid Services.

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

Contract Management Team – A group of CMS and Minnesota Department of Human Services staff responsible for overseeing the Demonstration.

Covered Services – The set of required services offered by the MSHO Plans.

Department of Human Services – The Minnesota Department of Human Services, the state agency which oversees the Minnesota Medicaid program known as Medical Assistance.

Enrollee – An individual enrolled in MSHO.

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

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

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

Grievance – An expression of dissatisfaction about any matter other than an Action including but not limited to the quality of care or services provided or failure to respect the Enrollee's rights.

Healthcare Effectiveness Data and Information Set (**HEDIS)** – Tool developed and maintained by the National Committee for Quality Assurance that is used by MSHO 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.

Health Outcomes Survey-Modified (HOS-M) – Formerly the Program for All-Inclusive Care Health Survey, the survey is administered by CMS to vulnerable Medicare beneficiaries at greatest risk for poor health outcomes.

Long Term Services and Supports (LTSS) – A range services and supports that help people with disabilities or functional limitations meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period and include those services designed to meet a Beneficiary's needs in their homes, as well as in facility-based settings such as nursing homes.

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

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

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

Medicare – Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End 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.

Minnesota Senior Health Options (MSHO) – A Minnesota health care program that combines separate health programs and support systems, integrating primary, acute, and long-term care services, for people ages 65 and older who are eligible for Medical Assistance and enrolled in Medicare Parts A and B.

MSHO Plan – Managed care organizations (MCOs) that are also qualified as Dual Eligible Medicare Special Needs Plans (D-SNPs) contracting with the State of Minnesota for the Minnesota Senior Health Options program. This MOU refers to MSHO MCOs or MSHO SNPs where the context is specific to Medicare or Medicaid requirements. The participating plans include: Blue Plus (H2425), HealthPartners (H2422), Itasca Medical Care (H2417), Medica Health Plans (H2458), Metropolitan Health Plan (H2457)[2], PrimeWest Health (H2416), South Country Health Alliance (H2419), and UCare Minnesota (H2456).

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

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

State – The State of Minnesota.

[2] Metropolitan Health Plan (H2457) did not renew its contract beginning January 1, 2015.

Appendix 2: Details of State Demonstration Area

The Demonstration will be effective statewide to the extent that MSHO continues to operate in all counties.

Appendix 3: Capitation Payment to MSHO Plans

Medicare Bid Process for MSHO Plans. Under the Demonstration, MSHO SNPs will continue to comply with Medicare Advantage and Medicare Part D bid rules. In accordance with current CMS bid review and audit requirements, MSHO SNPs will continue to provide supporting documentation of all data, assumptions, and methods used to develop the estimates of Medicare covered services contained in the Bid Pricing Tool (BPT) upon request of bid reviewers and auditors. However, auditors and desk reviewers will consider the provisions below in reviewing MSHO SNPs:

A. Integrated Claims Adjudication

1. Consistent with current practice, MSHO SNPs may process an integrated set of claims, rather than differentiate Medicare from Medicaid services.
2. CMS will provide clear guidance to claims process auditors that integration of Medicare and Medicaid claims adjudication is allowed. If requested by auditors, MSHO SNPs will provide plan-specific documentation regarding the approach used for the allocation of expenditures between Medicare and Medicaid by service category.
3. If MSHO SNPs and their certifying actuaries decide to overwrite the default formulas for beneficiary cost sharing in Worksheet 4, Section IIB, column f, MSHO SNPs will provide documentation regarding the development and methodology of the Medicare cost sharing percentages upon request of the bid reviewer or auditor. The methodology will be based on plan-specific data experience and include documentation of the allocation approach between Medicare and Medicaid by service category.

B. Considerations in the Bid Review Process

1. Because MSHO exclusively serves low-income Medicare-Medicaid enrollees, the program's viability is dependent on ensuring zero member premiums. Under Medicare Advantage/Part D payment rules, the lower a plan's bid, the greater the probability of having no beneficiary premium for low-income beneficiaries. Medicare Advantage/Part D bidding rules related to margin requirements place some constraints on plan sponsors in how they develop their bids.
2. Under this Demonstration, MSHO SNPs will continue to provide benefits that are at least equivalent to Medicare basic benefit levels for both Medicare Advantage and Medicare Part D, with capitation payments based on the submission of Medicare Advantage and Medicare Part D bids.

3. Also under this Demonstration, the Medicare Advantage/Part D bidding rules for how MSHO Plans determine their margin requirements will be broadened to allow lower margins to be included in the bids, starting with the 2015 bid year.
    a. Specifically, the margin requirements for these plans will be the same as for all other Medicare Advantage/Part D sponsors, but in the event that strict adherence to bid requirements results in member premium in the bids submitted the first Monday in June, and where margins have a minimum of zero, the margin requirements will be broadened to also accept one of the following. The aggregate margin, as measured by a percentage of revenue, may be either (1) no greater than 1.5 percent above the MSHO Plan's margin for all non-Medicare health insurance lines of business combined or (2) less than or equal to the margin for the Medicaid portion of the MSHO rate established by the State and approved by CMS.
    b. The intent of this margin flexibility is to reduce the likelihood of member premium related to maintaining margins comparable to other lines of business, while maintaining the fundamental incentives for competitive bidding and avoiding non-competitive practices. In any instances where margins are permitted under this Demonstration that would not otherwise be allowed in the prevailing bid requirements, MSHO Plans must demonstrate to CMS that the bids do not reflect anti-competitive practices relative to other D-SNPs in Minnesota.
    c. All other prevailing bid requirements will apply, and there is no guarantee that MSHO Plans will not be required to charge premiums.

Appendix 4: Demonstration Parameters

This Appendix describes the parameters that CMS and the State have established to govern this Federal-State partnership. The following sections explain details of the Demonstration that deviate from existing Medicare Advantage (MA) rules or procedures for Special Needs Plans (SNPs) or from Part D rules and processes. In some instances, existing arrangements between CMS and the State of Minnesota have allowed flexibility for MSHO SNPs because of the integrated nature of the program. However, many of these flexibilities have been developed through informal agreements. The parameters of the Demonstration as outlined in the MOU and appendices set forth the policies by which CMS and the State will operate for the life of the Demonstration. Where waivers from current Medicare are required, such waivers are indicated in Appendix 5.

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

The Minnesota Department of Human Services (DHS) is the single state agency for the Medicaid program. The DHS Commissioner oversees the human services agencies and offices that will be involved with implementing and monitoring the Demonstration.

The Minnesota Medicaid Director reports to the Commissioner and will oversee the Demonstration through his or her Special Needs Purchasing Manager, who will report to the Medicaid Director on all aspects of the Demonstration. The State will develop a work plan, subject to CMS review and approval, which will include detailed parameters of the initiative as related to the items defined herein in Appendix 4.

II. State Level Enrollment and Disenrollment Operations Requirements

a) Eligible Populations – All individuals enrolling in or currently enrolled in MSHO will be a part of this Demonstration, as described in the body of the MOU.

b) Enrollment and Disenrollment Processes – The Demonstration will use an integrated enrollment system to simplify the enrollment experience for Beneficiaries and improve the accuracy of the enrollment process.

   i. Integrated enrollment system:

      a. Currently the State serves as a third-party administrator (TPA) for some MSHO Plans to facilitate coordinated enrollment. This mechanism will be maintained, and enhanced, as necessary.

b. Uniform Enrollment and Disenrollment Letters and Forms - Beneficiaries will enroll and disenroll from Medicare and Medicaid managed care simultaneously through an integrated form, notices, and process. The State will test new, simplified language on enrollment forms and notices, subject to CMS approval.

ii. Accuracy of the Enrollment Process:

a. Data in State and CMS systems will be reconciled on a timely basis to prevent discrepancies between the systems. For example, for the purpose of sending forms and notices, the Demonstration will use updated State mailing addresses where the State addresses are more likely to be more accurate than the addresses from CMS.

b. Enrollment Effective Date(s) – D-SNPs are typically required to submit beneficiary enrollment requests to CMS within 7 days of verification. However, MSHO SNPs are currently exempted from requirements related to timely reporting of enrollments to allow time for Medicaid enrollments to be verified and finalized. In the demonstration, they will continue to be exempt from 7 day timeliness reporting requirements. This process allows for the completion of the Medicaid eligibility process prior to enrollment in the plan and enables the MSHO Plans and the State to promote overall integration of the enrollment process.

c) Under the Demonstration, the State and MSHO Plans are permitted to provide notices, as approved by CMS, to clarify beneficiary benefits under Medicaid, and ensure that Beneficiaries are provided complete and accurate information, following CMS Medicare communications with Beneficiaries.

III. State Level Delivery System Requirements

Delivery system and care model requirements will continue to be established through separate Medicare Advantage Special Needs Plan contracts and State Medicaid contracts with the MSHO Plans. However, the following reforms and administrative changes will be implemented to the delivery system to enhance the Beneficiary experience under MSHO:

a) **Network Adequacy -** MSHO Plans have all demonstrated compliance with State network requirements for long term services and supports or other Medicaid services, and all have previously completed the Medicare Advantage network review.

The Demonstration will not fundamentally change either the State or Medicare Advantage methodology for determining provider network standards. However,

under this Demonstration, CMS (or its designated contractor) will work with the State to conduct a new network review for all MSHO Plans. The review process will begin in 2014 and be applicable for a contract year no earlier than contract year 2015. As part of the Demonstration, CMS will test new standards that apply the existing Medicare Advantage methodology to the Medicare-Medicaid population in order to more accurately reflect where the Medicare-Medicaid population resides. In addition, the State will have an opportunity to participate in the review of network submissions and provide input to CMS on local delivery system considerations. CMS and the State will concurrently review MSHO networks, and MSHO Plans will be required to address any network deficiencies identified in the review.

b) **Benefits –** All covered benefits and medical necessity criteria will be governed by Medicare Advantage/Part D, and Medicaid contracts with MSHO Plans. This Demonstration does not change current benefits or medical necessity determination criteria for MSHO Enrollees, except that CMS will work with the State to explore options for MCOs to reduce Part D co-pays for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. Any changes would be incorporated into the annual bid process and subject to CMS approval and be implemented no earlier than MSHO SNP 2015 contracting year.

c) **Rebates** – Through the Medicare Advantage rebate process, MSHO SNPs may provide additional benefits to Enrollees. To ensure that benefits are consistently coordinated and plans do not provide benefits traditionally covered under the Medicaid capitation payment, the State will be involved in coordinating Medicare Advantage rebate benefits as outlined in section 3.9.5 of the 2013 MSHO/MSC+ contract.[3] Prior to submission of the initial annual Medicare Advantage bids to CMS, the MSHO Plan will consult with the State about any proposed changes in benefits. The MSHO Plan agrees to apply any Medicare savings not utilized to buy down the Medicare Part D premium to meet the LIS standard in accordance with CMS guidance or required to be returned to CMS, for the benefit of dually eligible Enrollees of the SNP, and agrees to consult with the State about any such benefits offered prior to the initial submission of the bids to CMS. If there are significant changes after CMS approval, the MCO agrees to notify the State of changes in such benefits following the approval of the bid.

[3] Contracts for all Minnesota MSHO/MSC+ MCOs are available online here: MN Plan Contracts

d) **Health Care Homes** - MSHO SNPs will be allowed to integrate Medicare and Medicaid primary care payments to facilitate Health Care Homes (HCHs) as outlined in sections 3.7.2(L), 9.10.3 and Appendix V of the 2013 MSHO/MSC+ contract. In general, certified HCHs in Minnesota are paid an additional payment for coordination of care. MSHO Plans are required to either pay this fee or use an alternative payment arrangement to be reported to the State under sections 3.7.2 (L) and 9.10.3 of the contract. The State (in consultation with the MCOs) has developed Integrated Care System Partnerships (ICSPs). These ICSPs will allow for the MSHO Plans to use alternate payment approaches that integrate the HCH model with the primary and specialty care coordination requirements for Medicare-Medicaid eligible Beneficiaries. ICSPs include a variety of providers of care coordination, and may include HCHs. Appendix V of the MSHO/MSC+ contract further details ICSPs and Minnesota's efforts to increase care coordination among MCOs and providers.

e) **Model of Care -** Under the Medicare Advantage program, a Special Needs Plan is required to have a model of care. All SNPs' models of care must be approved by NCQA based on CMS standards and the requirements in 42 CFR §§ 422.4(a)(iv), 422.101(f), and 422.152(g).

Prior to the next scheduled MOC submission for each MSHO SNP, CMS will give the State an opportunity to tailor the MOC elements, to reflect the MSHO requirements and processes, subject to CMS approval.

IV. Participating Plan Marketing, Outreach, and Education Activity

The Demonstration will integrate and simplify member materials. MSHO Plans will be required to use integrated documents created by CMS as part of the financial alignment model, or may adapt these documents with State and CMS approval. In addition, the following will be implemented for all MSHO Plans:

a) Antidiscrimination language - The State and CMS will resolve differences and/or streamline antidiscrimination language between Medicare and State Medicaid requirements for inclusion in marketing materials.

b) Marketing and Enrollee Communication Standards for MSHO Plans - MSHO Plans will be subject to rules governing their marketing and Enrollee communications as specified under section 1851(h) of the Social Security Act; 42 CFR § 422.111, § 422.2260 et. seq., § 423.120(b) and (c), § 423.128, and § 423.2260 et. seq.; and the Medicare Marketing Guidelines. For this demonstration, the MSHO Plans will adopt language block and reading level requirements consistent with existing Minnesota Medicaid requirements, where such requirements exceed Medicare standards.

c) Review and Approval of Plan Marketing and Enrollee Communications –

   i. The State will use a collaborative MSHO Plan Member Materials Workgroup for development of model materials for MSHO Plans in this demonstration, based on the integrated model materials developed for Medicare-Medicaid Plans participating in the CMS financial alignment demonstrations.

   ii. The State will submit the model integrated materials to CMS for review and approval prior to use by MSHO Plans.

   iii. Plans must submit all required marketing and communication materials, whether using model demonstration materials or modified versions of them, via the CMS Health Plan Management System Marketing Module. Dedicated coordinators at the CMS regional office will facilitate the review of all categories of materials required to be prospectively reviewed. CMS will establish a concurrent joint CMS and State approval process in the CMS Health Plan Management System Marketing Module starting for contract year use beginning in 2015.

   iv. CMS will defer to the State for review of certain types of educational materials and Enrollee communications, as agreed to in advance by both parties, such as those materials used at educational events, and communications between plans and providers.

d) Minimum Required Marketing and Enrollee Communications Materials - At a minimum, the State and CMS will work with Plans to adapt the following materials (with model templates to be reviewed and approved by CMS and the State) to align with Medicaid required materials for contract year use beginning in 2014:

   i. 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.

   ii. A Drug List summarizing the Medicare Part D and Medicaid pharmacy benefits available through the MSHO Plans.

e) Additional materials will be modified for contract year use beginning in 2015, such as:

   i. 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.

   ii. A combined Provider and Pharmacy directory outlining participating Medicare and Medicaid providers.

   iii. An integrated Enrollment Form allowing beneficiaries to enroll and disenroll from Medicare and Medicaid simultaneously.

iv. A Member Handbook, otherwise known as an Evidence of Coverage, describing the integrated benefits available through Medicare and Medicaid. Used in conjunction with the ANOC, MSHO Plans would not provide a Low Income Subsidy (LIS) Rider.

f) Notification of Formulary Changes - MSHO Plans must provide at least 60 days advance notice regarding Part D formulary changes, outpatient prescription or over-the-counter drugs or products covered under Medicaid or as supplemental benefits, consistent with 42 CFR § 423.120(b)(5).

V. Administration and Oversight

a) Oversight Framework

Under the Demonstration, there will be a CMS-State Contract Management Team established to ensure access, quality, program integrity, financial solvency, and compliance with applicable laws, including but not limited to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the ADA, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require MSHO Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse, with policies and procedures in place at both the plan and the third-party levels in the delivery of MSHO benefits, including prescription drugs, medical care, and long term services and supports. The Contract Management Team will also be responsible for addressing concerns that arise in the daily administration of the MSHO program that would result in reduced integration of the Medicare and Medicaid components of the program. In addition, all Part D requirements and Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to MSHO Plans by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations. The Contract Management Team will be informed about these activities but will not take an active part in these ongoing projects or activities.

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. The State may not take a unilateral enforcement action relating to day-to-day oversight without notifying CMS in advance.

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, Contract Management Team will undertake subsequent action and coordination.

b) Access to the CMS Health Plan Management System

Currently the Medicaid and Medicare Advantage contracting processes are evaluated through separate means by the State and CMS, respectively. Through the Demonstration, CMS will also provide State users with access to HPMS, upon completion of the CMS system access requirements, so the State can directly access network, marketing, and other information.

c) Fully Integrated Dual Eligible (FIDE) SNP Status

Throughout the Demonstration, participating MSHO Plans will provide clinical and financial integration of Medicare and Medicaid benefits and will continue to provide primary, acute, LTSS, and behavioral health benefits consistent with State policy, CMS policy, and this MOU.

Nothing in this MOU is intended to impact whether participating MSHO Plans are eligible to qualify for FIDE SNP status by following the Qualification Process for FIDE SNPs and submitting the appropriate FIDE SNP Contract Review Matrix as outlined in the 2014 Advance Notice and Call Letter for 2014 or subsequent versions. Participating MSHO Plans will remain eligible to qualify for FIDE SNP frailty adjustments if they meet criteria for that adjustment as outlined in Section K of the 2014 Advance Notice and Call Letter or subsequent versions. Participating MSHO Plans will also remain eligible for benefit flexibilities outlined in Section II Part C of the 2014 Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter "Benefit Flexibility for Certain Special Needs Plans" and "SNP Annual Notice of Change and Evidence of Coverage Requirements," provided criteria for this flexibility is met.

d) Cost Plan Monitoring

CMS will require MSHO Plans that are a parent organization of, share a parent organization with, or are a subsidiary of a parent organization offering an 1876 reasonable cost contract to provide additional information on plan enrollment in order to ensure the waiver of regulations at 42 CFR §§422.503(b)(4)(vi)(G)(5)(i)-(ii) does not allow an entity to move an enrollee from an MSHO Plan to an 1876 reasonable cost contract based on financial or other reasons that may not be in the Enrollee's best interest. On an annual basis, as applicable, MSHO Plans will report to CMS the number of beneficiaries who disenroll from an MSHO Plan and enroll in the same corporate parent or subsidiary company's 1876 reasonable cost contract during a time that they are still eligible to enroll in MSHO. The report shall be delivered to CMS annually by July 15. If CMS identifies a pattern of disenrollment exceeding two percent of the plan's total MSHO enrollment, from MSHO into a 1876

reasonable cost plan run by the same parent organization, CMS will notify the parent organization, further investigate enrollment patterns, and may require corrective actions. If such a pattern persists for an MSHO Plan, CMS may rescind the waiver of regulations at 42 CFR §§422.503(b)(4)(vi)(G)(5)(i)-(ii) for such MSHO Plan as outlined in this MOU. Upon such waiver termination, the reporting requirements for MSHO Plans operating under the same parent company with an 1876 reasonable cost contract would no longer be applicable.

e) Unified Quality Metrics and Reporting

MSHO Plans will continue to report quality measures and other data as required in their Medicare and Medicaid contracts, including HEDIS, HOS, and CAHPS data. All existing Part D metrics will be collected as well. MSHO Plans will continue to participate in Star quality rating systems. This Demonstration will not change the methodology for determining bonus payments to MSHO Plans.

In addition to those quality reporting requirements, under this Demonstration CMS and the State will test the following adjustments and additions:

1. Quality ratings – The State and CMS will collaborate with MSHO Plans to initiate the development and testing of measures that could be incorporated into an Integrated Care Star Measures model for MSHO Plans serving seniors. This approach may include state-specific measures that assess quality in areas outside of the Medicare benefit package, such as long-term supports and services and behavioral health. The modified approach will be in addition to ongoing CMS measurement on the current Stars system to avoid disruption of payment processes. The modified approach would not be posted on the Medicare Plan Finder during the testing and development process.
2. CAHPS – Currently, the State and CMS separately administer CAHPS. This creates inefficiencies for the MSHO Plans and burden for the MSHO Enrollees that are asked to respond to surveys that overlap significantly. The State and CMS will collaborate on the administration and results of CAHPS surveys, including by:
    a. Streamlining the number of CAHPS surveys administered by using a single CAHPS at the plan (PBP) level that meets both State and Federal requirements.
    b. Sharing individual level survey data from CMS with the State, so that the same Enrollee is being sampled only once for both the state and Federal surveys. Sharing would be subject to applicable privacy laws and to the completion of a Data Users Agreement by the State. This will allow the State to conduct State-specific analyses on CAHPS results, including for State initiatives to monitor and reduce health disparities.

c. CMS would also allow the State to add a limited number of additional questions to the survey.

3. Language access – Today, the HOS is administered in English and Spanish. Subject to funding availability, CMS and the State will make the HOS available in additional languages as warranted by the population in MSHO (e.g., Hmong and Somali) to better reflect the prevalent populations in MSHO.

4. Measurement revisions and development:

   a. Developing and testing ways to adapt existing provider level measures for application at the MCO/SNP level. For instance, disease/condition-specific outcome measures could be adapted for use in the plan environment, such as measurements of beta blocker therapy use for heart failure patients. These would be reviewed and modified for use at the MCO/SNP level.

   b. Developing and testing new measures

      i. The State will work with a national consensus building organization on the development of new measures, or modifications of existing measures that measure intermediate outcome or outcome measures. The State would also participate in a separate research project on feasibility testing of new measures for integrated programs for Medicare-Medicaid Beneficiaries (dependent on obtaining funding for the project). One important focus of this effort will be integration of care measures involving assessment and care planning, including LTSS services.

      ii. The State will include any specific changes to measurement standards in the work plan to be approved by CMS.

      iii. CMS will work closely with the State to identify other measures related to community integration. Once identified, CMS and the State will continue to work jointly to refine and update these quality measures, as necessary.

5. Performance improvement – The State will work with MSHO Plans and CMS to design and implement efficient mechanisms for reducing duplicate reporting requirements. This will include coordinating external quality reviews conducted by the QIO and EQRO. The changes would be designed to create efficiencies between Medicare and Medicaid for Performance Improvement Projects (PIPs), Quality Improvement Projects (QIPs), and Chronic Care Improvement Projects (CCIPs).

   a. CMS will allow the State to have input into topics selected for PIPs, QIPs, and CCIPs, including incorporating best practices as identified through the QIO to focus on topics that provide information and insights relevant to the population involved in this Demonstration.

b. MSHO Plans will use the existing Medicare QIP format when developing Medicaid PIPs and align timeframes as necessary to meet both Medicare and Medicaid requirements for all individuals eligible to enroll in MSHO (including those who do not choose to enroll).

VI. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of this Demonstration. The evaluator will explore how the Demonstration impacts beneficiary perspectives and experiences, and administration and benefit/service costs. The key issues targeted by the evaluation will include (but are not limited to):

- Administrative and systems changes and their impact on the MSHO program;
- Beneficiary satisfaction and experience;
- Quality of care provided across care settings; and
- Beneficiary access to and utilization of care across care settings.

The evaluator will design a State-specific evaluation plan for the 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 may 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 submit Minnesota-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Minnesota is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Minnesota and MSHO 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 work plan. Minnesota will ensure that Medicaid Statistical Information System (MSIS) reporting meets all reporting requirements regarding timing of submissions.

Appendix 5: Demonstration Waiver Authorities

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, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities.

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 "[t]he 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:

- § 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.

- The provisions regarding deemed approval of marketing materials in §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.

- §1853, §1854, and §1860D-11, of the Social Security Act, and implementing regulations at 42 CFR §422, subparts F and G, and §423, subparts F and G, only insofar as such

provisions are inconsistent with the methodology for determining payments and Enrollee liability under the Demonstration as specified in this MOU, including Appendix 3.

- Regulations at 42 CFR §§422.503(b)(4)(vi)(G)(5)(i)-(ii) (adopted pursuant to authority at § 1856(b) of the Act and effective July 22, 2014) only insofar as such provisions would prohibit the enrollment of new enrollees into section 1876 reasonable cost contracts offered by entities whose corporate affiliates also offer MSHO plans. We are waiving 42 CFR §§422.503(b)(4)(vi)(G)(5)(i)-(ii) for the purpose of allowing MSHO plans to operate a D-SNP while their corporate parent organization or a subsidiary concurrently accepts new enrollment in separate plans administered through section 1876 reasonable cost contracts. For each MSHO Plan, the waiver of CFR §§422.503(b)(4)(vi)(G)(5)(i)-(ii) is contingent on compliance with the cost plan monitoring requirements under Section III.V.d of Appendix 4 of this MOU, including any requirements under a corrective action plan.