

## **DRAFT CMS DESIGN PROPOSAL FOR PUBLIC COMMENT**

(updated March 22, 2012 with minor technical edits and clarifications)

### **Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota**

#### **A. Introduction: Issues for People with Dual Eligibility for Medicare and Medicaid**

Care for the nation's 10 million people dually eligible for Medicare and Medicaid has historically been fragmented, complex and confusing. Medicare pays for primary, acute and pharmacy care, while Medicaid provides primary and acute and long term care that wraps around the more limited Medicare benefit. Frail seniors and people with disabilities get multiple conflicting notices from Medicare and Medicaid without navigation assistance to figure them out. Even experts have difficulty sorting out overlapping and conflicting benefits and coverage requirements. There are conflicting clinical and payment incentives for providers and no one is accountable for total costs of care. Without any influence on primary and acute care payments, practices and networks which are controlled by Medicare, states have little leverage to control costs for dual eligibles. Medicare's primary and acute care systems drive most costs and include incentives for cost-shifting to long term care services paid by states. Costs for dual eligibles make up a disproportionate share of both Medicare and Medicaid expenditures and have been a growing focus of national attention as overall health care costs continue to rise.

Combining service delivery for Medicare and Medicaid through integrated financing provides a platform for aligning operational and financial incentives between Medicare and Medicaid pharmacy, primary, acute, post-acute and long term care services. Integrated financing is the first step in aligning provider service delivery and purchasing arrangements, supporting provider level payment reforms, increasing provider accountability and improving outcomes to improve costs, accountability and outcomes of care. Integration is also critical to simplifying access, reducing confusion and improving the experience of dual eligibles. Integrated financing for pharmacy benefits allows dually eligible individuals to use one card instead of the three now typically required (Medicare Part B, Medicare Part D and Medicaid) to access all pharmacy benefits. Benefit coverage determinations can be combined to avoid conflicting notices saying that benefits are not covered under one program when they actually will be covered under another part of the system. Member materials, enrollment forms, required notices, member services and other operational procedures can be integrated, reducing the complexity and number of forms people are faced with. Beneficiaries can develop long term relationships with assigned care coordinators or navigators familiar with their situations to assist with access to appropriate services and communications across health care providers, settings and financing sources.

#### **B. Medical Assistance (Medicaid) Reform in Minnesota**

Minnesota is reforming its Medicaid program to achieve better outcomes through twelve new initiatives designed to improve health, reduce reliance on institutional care, better align services to more effectively meet people's needs, promote community integration and independence and improve integration of Medicare and Medicaid. These reforms include payment and service delivery reforms such as an all payer Health Care Home (HCH) program, participation in the CMS Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), implementation of Health Care Delivery System Demonstration (HCDS) projects and Medicaid total cost of care (TCOC) payment pilot projects, as well as redesign of long term care services and supports. As part of the reform effort the Minnesota Department of Human Services (DHS) has also been charged with improving integration of Medicare and Medicaid. (See Medical Assistance Reform website and report: [www.dhs.state.Minnesota.us/MAreform](http://www.dhs.state.Minnesota.us/MAreform).)

A new CMS initiative, "State Demonstrations to Integrate Care for Dual Eligible Individuals," provides an opportunity for Minnesota to improve the integration of services for people who are dually eligible for Medicare and Medicaid services. Under this demonstration, the State of Minnesota proposes to re-design existing managed care programs for dual eligibles to promote aligned incentives for accountability for the total cost of care across both payers including provider based payment reform and care delivery innovations, with continued focus on person-centered individualized care coordination to achieve a seamless beneficiary experience. (See Minnesota's Demonstration to Integrate Care for Dual Eligibles website: <http://www.dhs.state.mn.us/dualdemo>)

**Premise**

Minnesota is a national leader in developing innovative aligned Medicaid payment and care delivery models for primary and acute care such as Health Care Homes and the Health Care Delivery System Demonstration and Medicaid total cost of care projects currently being implemented. Minnesota has also been a leader in integrating Medicare and Medicaid financing, obtaining approval for the first state Medicare demonstration for dually eligible seniors (later including people with disabilities) in 1995.

Under this new demonstration opportunity Minnesota proposes to combine these innovative HCH, HCDS/TCOC and dual integration efforts into a new, aligned purchasing model for seniors and to explore additional models for people with disabilities building on the recent expansion of managed care enrollment for people with disabilities. The new dual demonstration proposal provides a unique opportunity to re-design existing Medicare Advantage managed care programs to encourage provider-based partnerships that would increase accountability and improve outcomes.

The dual demonstration retains the advantages of integrated financing flexibilities provided under Medicare Advantage without some of the burdens, while allowing states to have a stronger role in contracting for Medicare services. This provides the State with a rare opportunity to influence Medicare primary, acute and post-acute care for dual eligibles through stimulating and incenting development of accountable, total cost of care models throughout the State.

**C. CMS Medicare and Medicaid Integration Demonstrations and Capitated Financing Model**

In February 2011, Minnesota responded to a CMS solicitation to provide up to 15 states with planning contracts to design demonstrations to integrate Medicare and Medicaid financing and service delivery for dually eligible people. In April of 2011 Minnesota was awarded a design contract with CMS to plan its new demonstration. In July 2011, CMS provided further guidance to States and an opportunity to choose between two pre-approved financing models (fee-for-service and capitation), which could be used in conjunction with the 15 States holding design contracts but were also open to other states. Consistent with current managed care programs for seniors and adults with disabilities, Minnesota submitted its letter of intent in October to pursue the Integrated Capitated Financing Model offered by CMS for seniors, with the potential of phasing in at a later date people with disabilities who have chosen to enroll in managed care. At least 25 other states are currently involved in developing capitated financing models for dually eligible populations.

Minnesota must publish a draft design proposal for a 30-day public comment period by March 19 and submit a final proposal to CMS by April 26. The proposal submission requires letters of support from the Governor Dayton and from stakeholder organizations. CMS timelines provide that significant financial and contracting details will continue to be negotiated after submission with many critical details around financing unlikely to be determined until after submission. The proposal requires that the State be prepared to implement the demonstration by January 1, 2013 and that three way contracts between CMS, the State and participating demonstration plans be signed by September 20, 2012.

**D. Demonstration Parameters**

The purpose of the dual demonstrations as explained by CMS is to reduce opportunities for cost shifting between providers and financing sources, to improve accountability for care outcomes and to result in a seamless beneficiary experience between the two programs. CMS demonstration requirements provide that Medicaid and Medicare primary, acute, behavioral health and long term care services and supports (LTSS) must be included under integrated Medicare/Medicaid capitations. Under the capitated financing model demonstration providers must meet Federal Medicare Advantage and Medicaid and State licensing and solvency requirements to participate in Medicare and Medicaid programs as risk bearing entities, including all requirements for providing Part D pharmacy benefits.

On January 25, 2012, CMS issued parameters for capitated financing model demonstrations which are very similar to Minnesota's existing integrated program for seniors but added new features such as the potential for states to share in any Medicare savings, authority for continued integration of operational procedures, and waivers of certain Medicare Advantage requirements not designed for dual eligibles including the financial bidding process while preserving all beneficiary protections. The parameters provide that the State and CMS develop a Memorandum of Understanding (MOU) and negotiate o three-way contracts with qualified demonstration entities to implement the

demonstration, allowing states' influence around the provision of Medicare services included under the demonstration. CMS also requires that the demonstrations produce savings, and that there be performance withholds. For the first time, CMS has the authority to make successful demonstrations permanent. CMS would also facilitate enrollment of dual eligibles into the integrated capitated demonstrations through an opt-out enrollment process, which is not currently allowed under Medicare.

#### E. Target Population

**Table 1: Target Population and Benefits Description**

<b>Target Population</b> (Based on January 2012 enrollment)	-All full benefit dual eligibles in all settings (including all institutional settings) who qualify for Medicaid managed care enrollment and choose to enroll in MSHO and SNBC. -Seniors 65 and older: 45,429 -People with disabilities 18-64: estimated about 18,300 after SNBC enrollment expansion and opt outs
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b> (January 2012)	106,178
<b>Total Number of Beneficiaries Eligible for Demonstration</b> (January 2012)	93,165
<b>Geographic Service Area</b>	-Seniors: Statewide -Disabilities: Statewide contingent on further negotiations with CMS
<b>Summary of Covered Benefits</b>	-Seniors and Disabilities: Medicare A, B, D and Medicaid State Plan including mental health and CD treatment services -Seniors: 1915(c) Elderly Waiver and all Medicaid Home Health, partial NF included -Disabilities: Partial NF and LTSS (PCA, PDN and CAC, CADI, BI and I/DD 1915(c) waivers *) under fee for service
<b>Financing Model</b> Is this proposal using a financial alignment model from the July 8 SMD? Payment Mechanism	-Yes -Seniors: Capitation -Disabilities: Capitation of State Plan services with shared accountability model for LTSS
<b>Summary of Stakeholder Engagement/Input</b> See Section T.	-Seniors Stakeholders Group: 3 meetings -Disability Managed Care Stakeholders Group: 31 meetings -Special Needs Plan Stakeholders Group: 5 meetings -Other Groups: 15 presentations -Website: <a href="http://www.dhs.state.mn.us/dualdemo">http://www.dhs.state.mn.us/dualdemo</a> Publication of Draft Proposal: March 19, 2012
<b>Proposed Implementation Date(s)</b>	December 2012 for seniors, 2013 for people with disabilities
*PCA-Personal Care Assistance, PDN-Private Duty Nursing, CAC-Community Alternative Care, CADI-Community Alternatives for Disabled Individuals, BI-Brain Injury, I/DD-Intellectual and Developmental Disabilities)	

#### **Dually Eligible Population and Enrollment Description**

There were about 51,786 full benefit dually eligible seniors enrolled in Medicaid in Minnesota in January 2012. (About 97% of all Medicaid eligible seniors are dually eligible.) Of this group, 44.2% are receiving home and community based services, primarily through the Elderly Waiver. About 28.3% are residing in nursing homes and 27.5% live in the community without Elderly Waiver services, but may qualify for personal care assistance.

As of January 2012, about 45,394 dually eligible seniors were enrolled in two statewide managed long term care programs offered by eight Medicaid health plans, all of which also sponsor Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). The new demonstration would include dually eligible seniors enrolled in Minnesota Senior Health Options (MSHO) which is currently integrated with Medicare through contracts with SNPs and serves about 36,037 dually eligible seniors, and Minnesota Senior Care Plus (MSC+), which is not integrated with Medicare and serves about 9,357 dually eligible seniors. Enrollment in MSC+ is mandatory for most Medicaid seniors, however seniors may choose to enroll in MSHO as an alternative. In addition about 35 seniors who turned 65 while enrolled in the Special Needs BasicCare program for people with disabilities chose to stay in that program as an alternative to MSC+. MSHO and MSC+ are managed long term care programs that enroll members in all settings and cover the same Medicaid benefits including long term services and supports (LTSS) and mental health services. Members who enroll in MSHO also receive all Medicare benefits through their D-SNP, including Part D pharmacy benefits. MSC+ members must choose a separate Part D plan. Most MSC+ members are enrolled in Original Medicare.

In January 2012, there were also about 54,392 people with disabilities aged 18 through 64 who were full benefit dually eligible in Minnesota. About 50% of all people with disabilities age 18-64 on Medicaid are dually eligible, but about 300 become dually eligible each month when their waiting period for Medicare benefits ends. About 47,736 full benefit dual eligibles are eligible for managed care enrollment in Special Needs BasicCare (SNBC), the State's managed care program for people with disabilities. SNBC includes most State plan services and all Medicaid mental health services and coordinates with LTSS which remain available through fee-for-service for enrolled members. SNBC operates in 78 of 87 counties and is expected to operate in all counties by the end of 2012. Enrollment in SNBC is being expanded, and as of March 1, 2012 SNBC serves about 21,500 members of which about 13,000 (61%) are dually eligible. SNBC is expected to grow to about 18,000 dually eligible members by the end of the year. SNBC began as an integrated program in 2008 but enrollment of dual eligibles was recently decoupled from Medicare because only three of the five SNBC plans have D-SNPs. There are about 1,102 dually eligible members enrolled in the three SNBC D-SNPs. Most SNBC members now receive Part D benefits through a separate Medicare plan. Overall, people with dual eligibility are slightly more likely to enroll in SNBC than non-dually eligible people.

### **Utilization Description (See Tables 2 and 3)**

The Average Annual Member Enrollment (AAME, defined as total member months divided by 12) for MSHO and MSC+ was 46,615 in state fiscal year 2011 (see Table 2). While MSHO accounted for just over 79% of the enrollment, enrollees in MSHO were more likely to be receiving LTSS than those on MSC+. The average age of MSHO members is 80 (range 65-111); while the average age for MSC+ members is 77 (range 65-108). Older enrollees are more likely to receive LTSS services, with those in institutional settings having an average age of 85, those receiving Elderly Waiver services having an average age of 80 and other community residents having an average age 74. Forty-seven percent (47%) of the population had a diagnosis of Alzheimer's or dementia, and nearly 51% of those residing in the community with LTSS had Alzheimer's or dementia while almost 74% of nursing home residents had an Alzheimer or dementia diagnosis. While those residing in the community are not receiving LTSS waiver services, 11.6% receive PCA services.

For State fiscal year 2011, AAME for dual eligible people with disabilities was 53,363. At that time, SNBC was a much smaller program, only enrolling about 5.7% of all dual eligible with disabilities (See Table 3). Overall, the vast majority of people with disabilities are served in the community, with 61.5% residing in the community with no LTSS services, an additional 33.7% receiving LTSS in the community and less than 5% residing in institutional settings. SNBC serves a higher percentage of members in LTSS services (43%), however the institutional population remains around 4.75% in both fee for service and managed care. During fiscal year 2011, people with Intellectual and Development Disabilities (I/DD) were more likely to remain on FFS than enroll in SNBC. Those enrolled in SNBC also used more PCA, Adult Foster Care (corporate, including customized living) and Mental Health Targeted Case Management (TCM) than those in FFS. This coincides with the greater use of waiver services among SNBC Enrollees, although nearly 9% of those living in the community without LTSS use PCA services.

**Table 2: Target Population for Phase 1: Dual Eligible Seniors (65+) (Data from State Fiscal Year 2011: July 1, 2010-June 30, 2011)**

	Total		Institutional-certified residing in Nursing Facility		Institutional-certified residing in community with Elderly Waiver Services		Institutional-certified residing in community with CAC, CADI, I/DD, BI Waiver Services		Residing in community with no waiver services	
	N <sup>1</sup>	%	N	%	N	%	N	%	N	%
<b>Target Population</b>	<b>46,615</b>	<b>100.00%</b>	<b>13,542</b>	<b>29.05%</b>	<b>18,962</b>	<b>40.68%</b>	<b>1,184</b>	<b>2.54%</b>	<b>12,927</b>	<b>27.73%</b>
<b>Age</b>										
65-74	16,691	35.81%	1,974	14.58%	5,949	31.37%	917	77.45%	7,852	60.74%
75-84	14,808	31.77%	3,790	27.99%	6,967	36.74%	224	18.90%	3,827	29.61%
85+	15,112	32.42%	7,778	57.44%	6,046	31.89%	43	3.59%	1,246	9.64%
<b>Current Plan</b>										
MSHO	36,917	79.20%	11,277	83.27%	15,348	80.94%	733	61.95%	9,559	73.94%
MSC+	9,698	20.80%	2,266	16.73%	3,614	19.06%	451	38.05%	3,368	26.06%
<b>Diagnoses</b>										
Dementia/Alzheimer's <sup>2</sup>	21,908	47.00%	9,990	73.77%	9,640	50.84%	305	25.72%	1,974	15.27%
SMI <sup>3</sup>	7,649	16.41%	3,776	27.88%	2,713	14.31%	376	31.77%	784	6.07%
SPMI <sup>4</sup>	600	1.29%	93	0.68%	318	1.68%	57	4.77%	133	1.03%
<b>Services</b>										
PCA	4,819	10.34%	11	0.08%	3,205	16.90%	97	8.22%	1,505	11.64%
Adult Daycare	2,000	4.29%	2	0.01%	1,796	9.47%	114	9.65%	87	0.67%
Assisted Living <sup>5</sup>	6,767	14.52%	43	0.32%	5,913	31.18%	666	56.23%	146	1.13%
Hospice	613	1.32%	532	3.93%	60	0.32%	2	0.18%	19	0.15%

<sup>1</sup> N is the Average Annual Member Enrollment (AAME), which is the total member months divided by 12.

<sup>2</sup> Dementia Alzheimer's defined using CMS CCW definition "Alzheimer's Disease and Related Disorders of Senile Dementia ([http://www.ccwdata.org/cs/groups/public/documents/document/ccw\\_conditioncategories.pdf](http://www.ccwdata.org/cs/groups/public/documents/document/ccw_conditioncategories.pdf))

<sup>3</sup> Definition of Serious Mental Illness (SMI): receiving Targeted Case Management (TCM) or ACT program services or ARMHS program services or a diagnosis of bi-polar disorder or schizophrenia or personality disorder or other psychotic disorder or having 2 or more inpatient stays with a primary diagnosis of depression or anxiety in the past two years. Diagnosis for bi-polar, schizophrenia, personality disorder or other psychotic disorder determined by 1 inpatient claim or 2 outpatient claims containing the diagnosis in the past two years.

<sup>4</sup> Definition of Serious and Persistent Mental Illness (SPMI): Receiving TCM or ACT Program services in the past two years.

<sup>5</sup> Includes Assisted Living, Residential Care, Adult Foster Care (corporate)

**Table 3: Target Population for Phase 2: Dual Eligible Persons with Disabilities (18-64) (Data from State Fiscal Year 2011: July 1, 2010-June 30, 2011)**

	Living Arrangements								Program			
	Total		Institutional-certified residing in Nursing Facility		Institutional-certified residing in community with HCBS Waiver Services (CAC, CADL, I/DD, BI)		Residing in community with no waiver services		SNBC		FFS	
	N <sup>6</sup>	%	N	%	N	%	N	%	N	%	N	%
<b>Target Population</b>	<b>53,363</b>	<b>100.00%</b>	<b>2,523</b>	<b>4.73%</b>	<b>17,989</b>	<b>33.71%</b>	<b>32,851</b>	<b>61.56%</b>	<b>3,055</b>	<b>5.73%</b>	<b>50,308</b>	<b>94.27%</b>
<b>Age</b>												
18-21	448	0.84%	4	0.15%	182	1.01%	263	0.80%	13	0.41%	435	0.87%
22-29	5,124	9.60%	46	1.81%	2,015	11.20%	3,064	9.33%	263	8.61%	4,861	9.66%
30-39	9,135	17.12%	136	5.39%	3,145	17.48%	5,854	17.82%	484	15.83%	8,651	17.20%
40-49	14,271	26.74%	529	20.95%	4,553	25.31%	9,190	27.97%	845	27.65%	13,426	26.69%
50-59	17,796	33.35%	1,147	45.48%	5,773	32.09%	10,876	33.11%	1,062	34.75%	16,734	33.26%
60-64	6,540	12.26%	656	25.99%	2,300	12.78%	3,584	10.91%	340	11.13%	6,200	12.32%
65+ <sup>7</sup>	49	0.09%	6	0.23%	22	0.12%	21	0.06%	49	1.61%	-	0.00%
<b>Current Program</b>												
SNBC	3,055	5.73%	146	5.77%	1,315	7.31%	1,595	4.85%				
FFS	50,308	94.27%	2,378	94.23%	16,674	92.69%	31,256	95.15%				
<b>SMI Only<sup>8</sup></b>												
	8,621	16.15%	99	3.92%	1,790	9.95%	6,732	20.49%	592	19.37%	8,029	15.96%
<b>Disability Types (may have more than one)</b>												
Intellectual/Developmental Disabilities	12,154	22.78%	1,203	47.67%	9,371	52.09%	1,581	4.81%	492	16.11%	11,662	23.18%
SMI <sup>9</sup>	21,641	40.55%	913	36.19%	7,389	41.08%	13,338	40.60%	1,479	48.40%	20,162	40.08%
SPMI <sup>10</sup>	8,048	15.08%	107	4.26%	2,507	13.94%	5,433	16.54%	627	20.52%	7,421	14.75%
Physical Disabilities	29,127	54.58%	2,005	79.48%	10,928	60.75%	16,194	49.30%	1,736	56.82%	27,391	54.45%
Chemical Dependency	18,996	35.60%	506	20.04%	4,298	23.89%	14,193	43.20%	1,085	35.52%	17,911	35.60%
<b>Services</b>												
PCA	4,763	8.93%	6	0.25%	1,829	10.17%	2,927	8.91%	384	12.56%	4,379	8.70%
Adult Foster Care <sup>11</sup>	3,157	5.92%	1	0.03%	3,156	17.55%	-	0.00%	300	9.81%	2,857	5.68%
Supported Living	6,745	12.64%	1	0.02%	6,744	37.49%	1	0.00%	284	9.29%	6,461	12.84%
Targeted Case Management	4,880	9.15%	31	1.23%	1,729	9.61%	3,120	9.50%	321	10.50%	4,560	9.06%

<sup>6</sup> N is the Average Annual Member Enrollment (AAME), which is the total member months divided by 12.

<sup>7</sup> Enrollees who turn 65 and are enrolled in SNBC may choose to stay enrolled in SNBC instead of changing to MSHO or MSC+.

<sup>8</sup> SMI Only is defined as a diagnosis of Serious Mental Illness (see below) with no diagnosis of I/DD or Physical Disabilities.

<sup>9</sup> Definition of Serious Mental Illness (SMI): receiving Targeted Case Management (TCM) or ACT program services or ARMHS program services or a diagnosis of bi-polar disorder or schizophrenia or personality disorder or other psychotic disorder or having 2 or more inpatient stays with a primary diagnosis of depression or anxiety in the past two years. Diagnosis for bi-polar, schizophrenia, personality disorder or other psychotic disorder determined by 1 inpatient claim or 2 outpatient claims containing the diagnosis in the past two years.

<sup>10</sup> Definition of Serious and Persistent Mental Illness (SPMI): Receiving TCM or ACT Program services in the past two years.

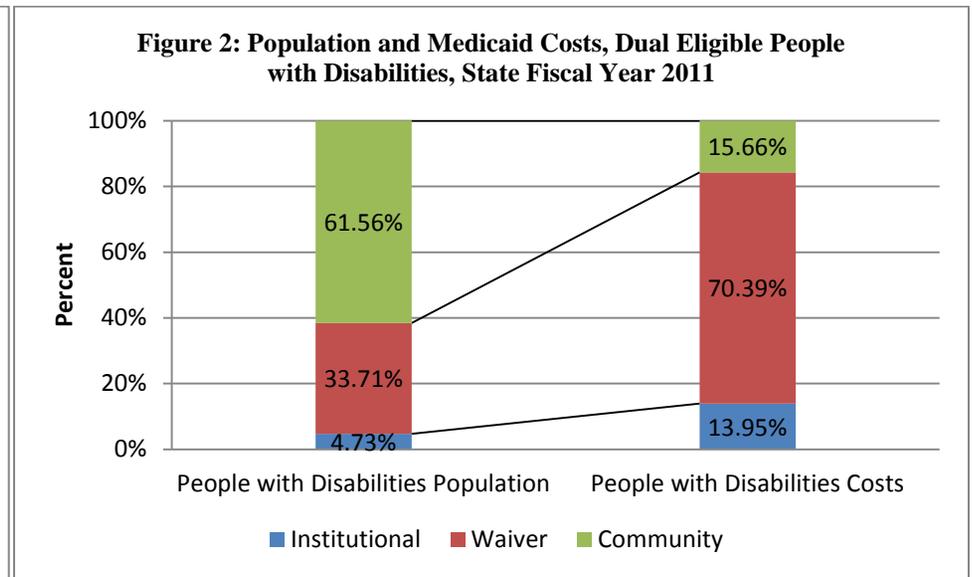
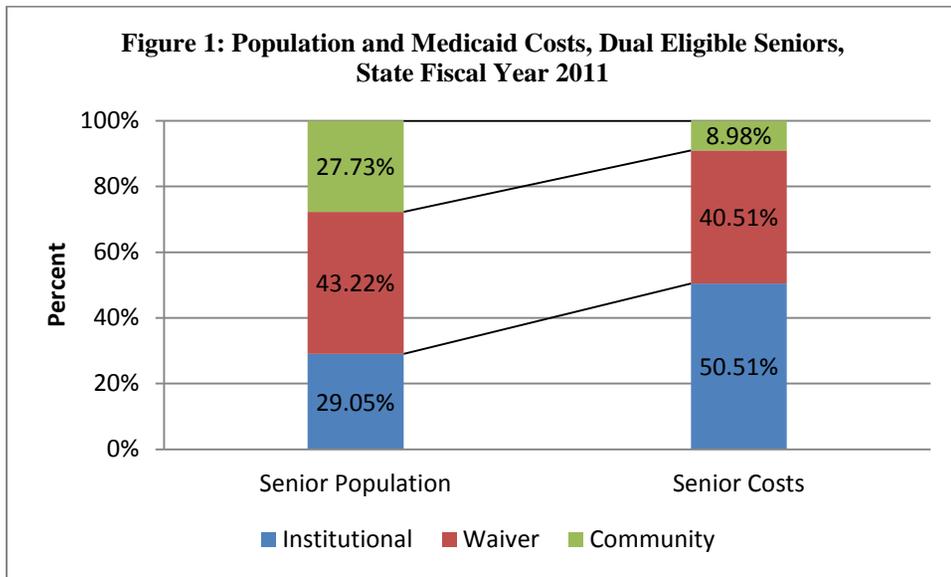
<sup>11</sup> Includes Corporate Adult Foster Care and Customized Living

**F. Total Spending For Dual Eligibles In Minnesota**

**Table 4: Total Medicaid Costs<sup>12</sup> for Duals Eligible to Participate in the Demonstration, State Fiscal Year 2011 (July 1, 2010 - June 30, 2011)**

	Institutional-certified residing in Nursing Facility		Institutional-certified residing in community with HCBS Waiver Services		Residing in community with no waiver services		Total	
	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM
<b>All Eligible Duals</b>	<b>\$838,206,344.00</b>	<b>\$4,347.88</b>	<b>\$1,444,601,574.00</b>	<b>\$3,156.80</b>	<b>\$321,006,614.00</b>	<b>\$584.35</b>	<b>\$2,603,814,533.00</b>	<b>\$2,170.32</b>
Seniors	\$656,153,879.00	\$4,037.67	\$ 526,183,248.00	\$2,176.56	\$116,642,739.00	\$751.91	\$1,298,979,866.00	\$2,322.15
MSHO	\$544,355,611.00	\$4,022.67	\$ 410,875,120.00	\$2,129.13	\$ 87,380,683.60	\$761.77	\$1,042,611,415.00	\$2,353.49
MSC+	\$111,798,268.00	\$4,112.35	\$ 115,308,128.00	\$2,364.23	\$ 29,262,055.20	\$723.93	\$ 256,368,451.00	\$2,202.88
Disabled	\$182,052,465.00	\$6,012.90	\$ 918,418,326.00	\$4,254.58	\$204,363,876.00	\$518.41	\$1,304,834,667.00	\$2,037.68
SNBC	\$ 9,531,007.93	\$5,455.64	\$ 76,924,574.10	\$4,875.12	\$ 14,817,153.90	\$774.31	\$ 101,272,736.00	\$2,762.34
FFS	\$172,521,457.00	\$6,047.02	\$ 841,493,752.00	\$4,205.64	\$189,546,722.00	\$505.36	\$1,203,561,931.00	\$1,993.67

Total Medicaid costs during fiscal year 2011 for people with dual eligibility who would be eligible to participate in the demonstration were \$2.6 billion, divided almost evenly between seniors and people with disabilities (see Table 4). For both seniors and people with disabilities, the majority of spending was focused on LTSS. In the senior population, over 90% of spending is for people who need long term care services with 50.5% of dollars spent for institutional residents, and another 40.5% going to LTSS waiver services for those in the community (see Figure 1). For people with disabilities, over 70% of all costs are focused on LTSS waiver services (see Figure 2). While average spending under SNBC is higher than for those receiving services under fee for service, risk scores for SNBC members have also been higher.



<sup>12</sup> Medicaid costs include all capitation and state plan or fee-for-service costs

## **G. Experience with Previous Demonstrations and Medicare Advantage Special Needs Plans**

Minnesota has been working with CMS to integrate Medicare and Medicaid services for people with dual eligibility since 1991. In 1995 Minnesota became the first state to obtain CMS approval for a Medicare payment demonstration that allowed fully integrated Medicare and Medicaid managed care contracts and financing covering primary, acute and long term care services for seniors in the Minneapolis-St. Paul metropolitan area. In 2001, people with disabilities were added to the demonstration. In 2005, with the advent of Part D and Medicare Advantage, CMS facilitated statewide expansion of the demonstration and transitioned the existing demonstration plans to Medicare Advantage Dual Eligible Special Needs Plan (MA D-SNP) status in order to preserve continuity of pharmacy coverage through the same organization under Medicare Part D. The demonstration was then phased out and contracts were separated between Medicare and Medicaid.

The Medicare Advantage D-SNP platform has been important to Minnesota's efforts to provide integrated Medicare and Medicaid financing for dual eligibles. However, the future of D-SNPs as a continued platform for Medicare/Medicaid integration remains unclear. Congress must reauthorize CMS authority for all SNPs before the end of 2012 in order for D-SNPs to continue. The financial bid processes under Medicare Advantage are not designed with dual eligibles in mind and can result in premiums that dual eligibles cannot pay. New Medicare Advantage payment reductions disadvantage states like Minnesota with lower than average Medicare benchmark payments. These reductions particularly disadvantage D-SNPs that serve high cost populations compared to regular Medicare plans serving younger active seniors.

The rate reductions and lower than average benchmarks have been particularly problematic for D-SNPs serving people with disabilities. Since 2009, a total of five D-SNPs serving people with disabilities in Minnesota have dropped out of Medicare Advantage citing financial viability reasons. While SNBC began as a fully integrated Medicare Medicaid option with seven D-SNPs in 2008, only three of the current five SNBC plans now offer Medicare D-SNPs for people with disabilities. D-SNPs serving people with disabilities in other states also have had problems and there is a widespread concern that Medicare Advantage risk adjustment systems do not accurately capture the needs of people with disabilities.

While all D-SNPs are required to have contracts with states for Medicaid services by 2013, CMS D-SNP rules are largely driven by broad Medicare Advantage policies, many of which do not consider the special issues related to integration of Medicaid and should not be applicable to programs serving dual eligibles. Despite the assistance of CMS staff, frequent SNP policy changes have made it a constant challenge to keep Medicaid policies aligned with Medicare and new Medicare requirements just announced for 2013 appear to make it much more challenging to retain an integrated system.

However, Medicare Advantage allows flexibility not normally found in other Medicare financing structures that are necessary for changing reducing cost shifting and for creating efficiencies in care delivery. For example, under Medicare Advantage, health plans are allowed to waive certain fee-for-service Medicare requirements such as the three day hospital stay for access to skilled nursing facility (SNF) care and to authorize payment for in lieu of hospitalization stays in nursing homes. Through Medicaid contracts with D-SNPs, Minnesota has leveraged some of these flexibilities such as waiving the three day hospital stay for access to SNF care and coverage of hospital in-lieu-of days in nursing homes when warranted. Medicare D-SNPs are required to provide care coordination for all members, so additional care coordination for people not eligible for such assistance under Medicaid has also been leveraged through integrated financing with D-SNPs. In addition, Medicare plans have some flexibility in interpreting Medicare coverage criteria, and can move away from fee-for-service based payment methods for clinics and post-acute providers such as SNFs. When coupled with immediate access to Medicaid home and community based care services through the Medicaid contract, this flexibility has allowed Minnesota D-SNPs to reduce re-hospitalization rates and to avoid long term institutional placements, allowing individuals to remain in their own homes or alternative settings.

Such flexibility and aligned financing are needed tools for managing costs but can also change payment and delivery incentives among payers and providers, as evidenced by innovative contracts between some MSHO health plans and HCH based clinics, "care systems," counties, and long term care providers. Some of these arrangements include partial or virtual capitation "payment reform" arrangements involving risk and gain sharing across Medicare and Medicaid for primary acute and long term care services. Some of these models report excellent outcomes and results.

However, providing the integrated financing and flexibilities alone does not necessarily encourage providers and health plans to enter into risk-based contracts or produce standardized systemically measurable outcomes indicating improved care. For various reasons including reluctance to take risk, relatively few plans and providers have entered into these arrangements and providers in many parts of the State have not ventured into these arrangements.

Under the new demonstration, CMS has proposed to extend some of the flexibilities available under Medicare Advantage to demonstration plans outside of Medicare Advantage. The dual demonstration provides the first wide scale opportunity to give states a larger role in influencing Medicare policy for dual eligibles. Under the demonstration, the State would be a party to the Medicare contract, allowing a stronger role in purchasing for these integrated primary, acute and long term care delivery systems. The State could also use this opportunity to develop and promote pathways for increased communications between HCH, counties and other providers where such integrated care systems are not possible. In addition, for the first time CMS has the authority to make successful dual demonstration models permanent, giving Minnesota a chance to apply its expertise in this area to shape a new national policy. A move back to demonstration status is timely for preserving Minnesota's investment in integrated care for dual eligibles and for improving integrated payment and service delivery models in accordance with other Medicaid reforms to ensure long term viability.

#### **H. Enrollment and Member Materials Integration**

Under the new demonstration authority, enrollment for the demonstration and Medicare services would continue to be voluntary. On January 1, 2013, current MSHO D-SNPs participating in MSHO would transition from Medicare Advantage D-SNP status to demonstration plans called Medicare/Medicaid Integrated Care Organizations (MMICOs). Enrollment for current members would continue seamlessly under the same plan sponsors to ensuring that current care for frail members is not disrupted while further purchasing reforms are being developed and implemented. Continued access to integrated Medicare, Medicaid and Part D financing for these MSHO members will be provided through the three-way integrated financing agreements with CMS for MMICOs.

The State proposes to keep its current integrated Medicare and Medicaid enrollment system in which the State provides expert Third Party Administrator (TPA) services to most participating plans and submits enrollments for members directly to CMS following all current Medicare Advantage enrollment and communication procedures. The plans not participating in the TPA arrangement currently must follow contract requirements for maintaining integrated enrollments and these enrollment procedures would remain in place. The State has had 15 years of experience with Medicare enrollment systems requirements under this enrollment process and it would be costly and disruptive to change it.

Currently, the State has long standing processes for accepting, managing and entering integrated enrollments and disenrollments at the state level. Enrollees may obtain enrollment forms from State mailings, participating plans, counties and State Health Insurance Counseling Programs (SHIP). The State does not use an enrollment broker. Participating SNP plans hire their own marketing staff and do not use independent brokers for SNP enrollments. Members may disenroll in any month by contacting the SNP, the State, the county or the Linkage Line staff, all of which can assist them with the process. Disenrollments for integrated programs are sent to the State for entry and processing to ensure that enrollment records remain integrated.

Consumer choice counseling is provided through counties and the SHIP programs. County managed care units inform all new Medical Assistance eligibles of their plan choices under MSC+ and MSHO and provide enrollment forms facilitated through their education activities to the State for verification and processing. In addition, the State SHIP Senior and Disability Linkage Lines are highly engaged in providing enrollment counseling to seniors and people with disabilities for integrated Medicare and Medicaid products and Part D. Enrollment materials and other processes refer prospective members of current programs to the Linkage Lines for additional assistance with these Medicare choices.

Because of the integrated nature of this process, D-SNPs have been allowed by CMS to forego enrollment through Medicare.gov. It is essential to retain the link to Medicaid eligibility for this demonstration, therefore the State requests that this authority be continued. The State's current Medicaid enrollment process also allows retroactive re-enrollment of members who temporarily lose Medicaid eligibility where eligibility is reinstated without interruption within 90 days. This coordinates with current SNP policy which allows Medicare D-SNPs to retain members for up to

six months after loss of Medicaid eligibility. While Medicaid makes no further payment until Medicaid eligibility is reinstated, D-SNPs have agreed to the State's standard of retaining members for Medicare for up to 90 days unless Medicaid eligibility is permanently terminated. It will be important to retain this feature under the new demonstration.

Transition from the current SNP programs to the new demonstration should be seamless for current members, based on previous experience when the State moved from demonstration status to SNP status in 2005 and 2006. The State proposes that each current SNP member would get a notice from the State (or a joint notice from the State and CMS) informing them that the MSHO and SNBC programs are moving to the demonstration and that enrollment their current plan will continue without disruption and that no action on their part is required. There would be no additional enrollment forms or opt out process needed for this group since all of these members are already voluntarily enrolled in an integrated Medicare/Medicaid plan. As would be the case normally, members would be notified of any potential changes in benefits through the Annual Notice of Change (ANOC) and the Evidence of Coverage (EOC) and members retain their right to disenroll at any time. The State would coordinate this notice with its normal open enrollment process which occurs in October-December of each year. This process will eliminate confusion and disruption in often intricate primary care and care plan arrangements and Part D coverage.

DHS also requests CMS permission for an opt-out enrollment process into the new Medicare demonstration for current dually eligible MSC+ members served by the same MMICO sponsors. Because MSC+ members are enrolled in a separate plan for Part D, MMICOs would be responsible for assuring continuation of current pharmacy benefits during a transition period. In its implementation budget request, the State requests funding for additional health insurance counseling staffing to assist with this transition.

Enrollment of people with disabilities into the Medicare/Medicaid demonstration would follow a similar process. However proceeding with enrollment for this group will be determined contingent on viable Medicare financial models reflecting state long term care policy for people with disabilities. CMS requires that Medicare enrollment be voluntary and that people have the right to opt out prior to enrollment and in any month thereafter. MMICOs would also be responsible for assuring continuity of current Part D pharmacy benefits for any enrollees with disabilities choosing to enroll.

### **Integrated Member Materials**

A priority for the State has been to ensure that member materials used by contracted D-SNPs are highly integrated to prevent confusing and conflicting messages to enrollees and to ensure consistency among all plans. Enrollment forms, Evidence of Coverage (EOC), member directories (including pharmacy directories), benefit determinations, notices and marketing materials are all currently integrated to the extent possible under current Medicare requirements. All D-SNPs and the State participate in the D-SNP Integrated Member Materials Workgroup which identifies timelines and materials that must be developed, reviews required changes in materials and mutually agrees on language and procedures that will best integrate Medicare and Medicaid objectives for any changes within state and federal parameters. The State works with the SNPs to develop model materials for the workgroup's review and when complete submits this to the CMS Regional Office for approval. Each plan submits their materials through HPMS as usual after adding any allowed plan specific information to the models. The Regional Office has appointed either a single reviewer, or more lately a review coordinator, to work with the State to resolve any questions about the model materials and to coordinate a consistent review among all of the Minnesota SNPs so that the Medicare contract manager reviews and approvals are consistent. While CMS has not yet clarified the role of the Regional Office in relation to this demonstration, we request that CMS continue to allow this highly effective approach with a single reviewer approving the model for all SNP materials and recommend that it be expanded to other participating States.

Because of the short timeframes for implementation, the State requests that member materials already approved by the State and the CMS Regional Office under this coordinated integrated member materials review process be utilized for the demonstration. Initially, to facilitate timely transition, we request that CMS move current approved materials from current "H" numbers to new "H" numbers under the demonstration. We also have recommended improvements in the timelines and the review process for materials that we would like to discuss with CMS such as shortening the time period for review when State model materials approved by the State and CMS are used by all participating plans. We also will explore with CMS the possibility of improving materials used for Part D. For example, language about formulary wrap around coverage from Medicaid should be added to make integrated programs more understandable to members.

The State requests that standardized forms currently required by Medicare for skilled nursing denials not be used under this demonstration. These forms indicate that the health plan will no longer pay, which is not true if the health plan is able to pay under the Medicaid benefit set, so is upsetting and confusing to the enrollee. The State proposes that an integrated form be allowed.

Enrollees will continue to be notified of any significant changes in networks, benefits or other provisions through member materials. Program changes and member materials for all enrollees of Minnesota Health Care Programs are also provided in alternative formats and must be accompanied by a language block including ten languages and information as to how interpreter services can be provided.

Under the demonstration the State requests that CMS defer Medicare language block requirements to the State. New Medicare SNP requirements exclude five of the most used languages in Minnesota such as Somali and Hmong, but include other languages not relevant to this area of the country so would not meet the needs of our enrollees.

#### **I. Geographic Service Area**

The demonstration would be statewide for seniors.

The SNBC managed care program for people with disabilities operates in 78 of 87 counties. However, only about 500 dual eligibles reside in counties without a current SNBC plan option. The State will issue an RFP for SNBC coverage in the nine uncovered counties shortly and expects that all counties will be covered by July of 2012. Only current SNBC contractors will be allowed to respond to the RFP. However, as stated earlier, the State needs more information from CMS about the financing model and then will consult further with internal and external stakeholders prior to finalizing the demonstration service area for people with disabilities.

#### **J. Provider Networks**

For purposes of initial CMS approval, MMICOs would utilize current integrated Medicare and Medicaid networks. MSHO networks are extensive and already include large numbers of providers for Medicare and Medicaid services as well as arrangements to pay non-participating providers out of network. Some current CMS network requirements may not be appropriate for dual eligibles where there are small numbers of members and where the State is encouraging more selective contracting with integrated care systems demonstrating expertise in serving dual populations. Additional network requirements for SNBC contracts require special provisions for robust transportation and durable medical supplies and equipment providers as well as extensive mental and behavioral health services and mental health targeted case management. The State requests that CMS accept existing D-SNP and MCO networks as part of the MMICO transition, that additional CMS HSD tables not be submitted, and that CMS defer to the State for approval and override of CMS network determinations.. These networks are currently in place and have already been approved by both the State and CMS as meeting CMS and State adequacy requirements. Under current requirements that would remain in place, significant network changes (including care system changes which result in changes in primary care physicians and also nurse practitioners) would continue to be reported to the State and CMS as well as to affected enrollees. Network and access requirements are listed in Section 6.10-23 of the current Seniors' and SNBC model contracts at the links provided below.

[http://www.dhs.state.mn.us/dhs16\\_166538.pdf](http://www.dhs.state.mn.us/dhs16_166538.pdf) and [http://www.dhs.state.mn.us/dhs16\\_166539.pdf](http://www.dhs.state.mn.us/dhs16_166539.pdf)

#### **K. Proposed Purchasing and Care Delivery Models (See Related Purchasing Models Chart Appendix 1)**

Under the umbrella of integrated Medicare and Medicaid financing created through the demonstration for the MMICOs, DHS will implement several service delivery and risk/gain sharing models with increasing levels of payment reform and risk/gain sharing arrangements designed to align with Statewide payment and delivery reforms and to improve accountability for care outcomes across providers and service settings. All models will have a primary focus on providing person centered care coordination and a seamless and simplified experience for the enrollee.

In particular, DHS will incorporate purchasing strategies similar to the HCDS models being implemented for other populations to stimulate new "integrated care system partnerships" (ICSPs) between MMICOs and providers which may include HCDS, , HCH/clinics and care systems, mental health providers, post-acute and long term care providers and/or counties. These partnerships would be designed to support payment and provider delivery reforms including risk/gain sharing similar to reform efforts now underway with other populations.

The State will create criteria for these partnerships including requirements to utilize certified health care homes, primary care payment reforms, integrated care delivery and care coordination across Medicare and Medicaid services, accountability for total costs of care across a range of services including long term care and/or mental health, shared risk and gain, coordination between primary care and other providers and counties, incentives to provide services in all settings to minimize cost shifting and enrollee choice of integrated care systems.

The State recognizes that not all areas of the State may be able to move as quickly to the more fully integrated models, so a range of flexible care delivery options is proposed below to reflect differences between rural and urban areas and populations, as well as variations among providers. However, the State's goal is to increase the number of dual eligibles served in integrated service delivery models as described in Models 2 and 3 where possible in order to maximize accountability, improve care outcomes and implement primary care payment reforms.

In addition, MMICO contracts and provider subcontracts will include standardized performance outcome measures to be applied to the integrated care systems and a portion of currently required Medicaid withhold payments will be tied to the new combined Medicare and Medicaid performance outcomes as required by CMS.

Since it will take more time to design RFPs and negotiate these new partnerships, additional Model 2 solicitations would be implemented in July 2013 for seniors.

Model 1 could also be available immediately for people with disabilities under the demonstration, and variations in Model 2 could be addressed to accommodate differences in the scope of benefits and care coordination for this population. Solicitation for additional participants for Models 2 and 3 for people with disabilities would be phased in later in the year pending agreement with CMS on a viable Medicare financing arrangement. Depending on negotiations with CMS, the State could pursue Model 3 for a targeted group as an alternative or in addition to Models 1 and 2.

Under the demonstration, care delivery will be based on three main components: Care Coordination, which builds on current managed care contracts and SNP Model of Care requirements for comprehensive assessment, interdisciplinary person centered care planning and ongoing monitoring; re-designed Service Delivery models which align with State purchasing and payment reforms for increased accountability and efficiencies in utilization; and Evidence-Based Practices designed to improve quality of care.

**a) Care Coordination**

For seniors, requirements for individualized care coordination across all services, health risk and comprehensive LTSS assessments, person centered care plans, interdisciplinary teams, standardized care plan audits and care system audits for seniors would remain under all systems. These are outlined in the current contracts and reflected in current SNP Models of Care. All entities providing care coordination must follow standard contract requirements, including initial health risk assessments within set timeframes, comprehensive assessments using the States' long term care consultation tool, and submission of screening documents including demographic and functional data directly to the State's MMIS system. Timely submission of screening documents for all community members is tracked by the State.

While care coordination requirements are the same across all entities, MMICOs and providers may have a variety of care coordination subcontracting arrangements. Care Coordination functions may continue to reside with primary care under the HCH, counties, tribes, community organizations, the MMICO, or the ICSP providers depending on the partnerships between MMICOs and providers within the models outlined below.

The State will develop and clarify measures to apply to all care system models consistent with other federal, state and community measurement efforts but adjusted as necessary to apply appropriately to dual eligibles, including those using long term care services and supports and mental health targeted case management. Requirements for oversight of care plans and care system audit functions, use of standard audit protocols and reporting would continue. (See Model MSHO/MSO+ Contract Articles 6.1.4-6, 7.9 and 9.3.9.)

[http://www.dhs.state.mn.us/dhs16\\_166538.pdf](http://www.dhs.state.mn.us/dhs16_166538.pdf)

For Seniors collaborative care plan audit protocols see: [http://www.dhs.state.mn.us/dhs16\\_167851](http://www.dhs.state.mn.us/dhs16_167851)

Collaborative efforts on Improving Care Transitions will also continue to be required for MMICOs. The current Minnesota D-SNP Transitions Collaborative includes all plans serving dual eligibles working together to develop and implement a standardized protocol for transitions including reporting and communications tools for care coordinators. Information on these transition plans are contained in the SNP Models of Care. Plans are also required to periodically review the status of members in nursing homes and provide relocation assistance for them to return to the community when appropriate. The D-SNPs also cooperate with Continuing Care's Return to Community Initiative which reviews new nursing home admissions and provides information about community care options to all nursing home members. When D-SNP members are identified they are referred to the care coordinator for assistance. Safe, effective and efficient care transitions will be a continued focus of new ICSP purchasing strategies under this demonstration. See below for training documents used by the Transitions Collaborative. [http://www.dhs.state.mn.us/dhs16\\_147554.pdf](http://www.dhs.state.mn.us/dhs16_147554.pdf)

In addition, for people with disabilities including those with mental illness/substance abuse, current care management, assessment, submission of screening documents to MMIS, and navigation assistance requirements under SNBC would continue. Additional care coordination requirements under Models 1 and 2 would be dependent on the financing arrangements negotiated with CMS. For current care management, navigation and care system audit requirements see Model SNBC Contract Article 6 (6.1.5-6), Article 9 (9.3.9). [http://www.dhs.state.mn.us/dhs16\\_166539.pdf](http://www.dhs.state.mn.us/dhs16_166539.pdf)

Additional care coordination enhancements to encourage further integration of physical and mental health under Model 3 below would be based on experience and requirements for the Preferred Integrated Network, a partnership between Medica and Dakota counties.

**b) Service Delivery Models**

**Model 1. Primary Care Health Care Homes “Virtual Care Systems”**

Under Model 1 all enrollees (seniors and people with disabilities) would choose a primary care clinic, preferably a certified HCH where available. The State currently has 156 HCHs certified with another 150 in process. Currently certified HCHs represent roughly 25% of all primary care clinics in Minnesota. With the additional clinics currently being added this will include about half of all primary care providers in the State. MMICOs would provide payments to HCHs as currently required under MSHO/MSC+ and SNBC contracts, unless alternative payment models have been negotiated (see Models 2 and 3). Risk and gain sharing is not required under Model 1. However, DHS will propose to CMS that HCH payments from MMICOs be considered an allowable cost for Medicare and be considered part of the initial Medicare cost base because Medicare is the primary payer and savings related to HCH would normally accrue to Medicare, not Medicaid. This would allow for the full integration of HCH payments into Medicare's primary care payments. Since not all clinics are certified as health care homes, MMICOs would also be required to develop provider contract requirements that provide incentives to their participating clinics to become HCHs and would facilitate member's clinic choices or assignments to primary care arrangements that are certified as health care homes unless that would disrupt current care relationships.

In addition, building on models being developed through the MAPCP Demonstration and the State's Administration on Aging grant for Integrated Systems Development, the State would develop and utilize standardized shared communication strategies and secure electronic communications tools to encourage “Virtual Care System” communications between MMICOs, HCH, counties, tribes, mental health, acute, post-acute and long term care providers to promote consistent care planning, safe transitions, reduce duplication and clarify roles for care plan follow up. The State is currently working with stakeholder groups to design communication tools and strategies to promote these communications. Recommendations for these tools will be available prior to implementation of the demonstration.

**Model 2. Integrated Care System Partnerships (ICSPs)**

Under this model, the State will issue (an) RFP(s) for new facilitated contracting arrangements for integrated care system partnerships (ICSPs) serving seniors /enrolled in the demonstration. (This model would also be adapted for people with disabilities at a later point pending negotiations with CMS.) These partnerships will involve providers and MMICOs in integrated delivery of primary, acute and long term care services to MMICO members. Long term care providers, counties, tribes and HCDS would be eligible to be ICSP sponsors as well as primary and acute care providers. Primary care providers involved in ICSPs would be required to be

certified as HCH. DHS will use elements and experience from existing MSHO care systems and HCDS to build RFP requirements for aligned financing across partners, encouraging aligned participation of acute and primary care health systems with post-acute and long term care providers and others including coordination with counties, mental health providers and tribes under contracts facilitated by the State with MMICOs. Criteria for these new partnerships would include: utilization of certified health care homes, implementation of primary care payment reforms, integrated care delivery and care coordination, accountability for total costs of care across a range of Medicare and Medicaid services including long term care services and supports and/or mental health, shared risk and gain, coordination between primary care and long term care providers and counties, incentives to provide care across settings and provider types to minimize cost shifting and preserve continuity of care, and enrollee choice of integrated care systems.

Enrollees would choose or be assigned (not attributed) to primary care arrangements within the ICSPs. Responsibility for individualized person centered care coordination would be assigned from the point of enrollment, assuring tracking of costs and outcomes and alignment and accountability throughout the continuum of care as well as continuity of care for members. Appropriate marketing protections to preserve enrollee choice of primary care provider will be included.

The RFP for these partnerships will require that interested ICSP provider sponsors partner with an MMICO to submit a joint response along with a proposed plan meeting RFP requirements for how they will work together under the demonstration. The RFP will specify parameters for standardized payment and risk/gain sharing arrangement options, including flexibility for graduated levels of risk/gain sharing across services and standardized risk adjusted outcome measures, and provider feedback mechanisms. DHS will be involved in facilitating contracts between ICSPs and MMICOs (similar to the current mental health Preferred Integrated Network (PIN) arrangements and HCDS models). MMICOs will retain primary risk and thus will be part of the contract negotiations with ICSP providers in their networks. Models may differ between geographic areas depending on population needs, interests and availability of providers and MMICO/provider/county and tribal relationships. The State (for work load management purposes) would have the right to limit the number of new ICSP participants.

**Current Care Systems with Alternative HCH Payments:** Some MSHO plans currently have alternative payment arrangements with provider sponsored care systems (clinics or physician groups) that include prospective full or partial capitations or care coordination payments for all or partial Medicare and Medicaid care coordination functions. These entities may or may not be HCH as the HCH statute allows such alternative payment arrangements for integrated programs serving dual eligibles, but through contract arrangements with current MSHO plans they perform duties similar to HCH for their enrolled members. Integration of Medicare and Medicaid payments under these models has allowed physicians to hire additional staff extenders such as nurse practitioners, RNs or social workers to assist with or provide care coordination. Payments may exceed what would be paid in a HCH because they also include payments for Medicare care coordination (still a requirement under the demonstration) as well as coordination of Medicaid LTSS. In some cases these also include risk and gain sharing models with virtual or actual sub-capitations for all services which may extend to sharing gains with long term care providers. Providers and MMICOS may wish to remain in these arrangements. These arrangements are currently reported to DHS. DHS will evaluate the existing arrangements to assist in building the criteria for the new ICSPs and to assure that existing arrangements also meet basic ICSP Model 2 criteria. Primary care providers that are not already certified as HCH under these current care systems would be required to participate as HCH and would be provided a transition period in order to accomplish this prior to any contract requirements.

Since it will take more time to design RFPs and negotiate these new partnerships and to offer enrollees choice of arrangements, Models 2 and 3 below would be implemented during 2013.

### **Model 3. SNBC Chemical, Mental and Physical Health Integration Partnerships**

Pending negotiations with CMS for transitioning SNBC plans to MMICOs under the dual demonstration, DHS (with leadership from the Continuing Care and Mental and Chemical Health Administrations) would establish criteria and issue RFPs for an ICSP between SNBC MMICOs, HCH/primary care, counties, mental health and substance abuse providers, tribes and /or long term care providers, for SNBC enrollees with primary diagnoses of mental illness including co-occurring substance abuse. The RFP would encourage integration of physical

health and chemical and mental health services under MMICOs serving people with disabilities ages 18 to 64 with primary diagnose of mental illness including co-occurring substance abuse. This could be modeled after the existing PIN mental health initiative which is a partnership between a county and an SNBC plan. The State also will continue to explore the Medicaid Health Home benefit and how it could be offered to a target group of enrollees as part of this model. A copy of the PIN contract is available at: [http://www.dhs.state.mn.us/dhs16\\_160040](http://www.dhs.state.mn.us/dhs16_160040).

c) **Evidence-Based Practices**

MMICOs/ICSPs will be encouraged through the RFP process and contract requirements to utilize evidence-based practices and guidelines to achieve specified improvements in outcomes for enrollees. While current health plans and providers commonly utilize evidence-based practices, the State will take a more active role in guiding this effort to ensure consistency and increased accountability. MMICO contracts will include standardized performance outcome measures to be applied to the ICSPs and other existing care systems and a portion of currently required Medicaid withhold payments will be tied to the new combined Medicare and Medicaid performance outcomes as required by CMS. Contract requirements for evidence-based disease management appropriate for seniors and people with disabilities for diabetes care and heart disease will also continue to be included under the demonstration.

Managed care contracts currently require that managed care organizations (MCOs) provide care that has a solid foundation in well-researched clinical practice. For example Article 7.2 of the Seniors contract states:

“The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices.

Adoption of practice guidelines. The MCO shall adopt guidelines that: 1) are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically as appropriate.”

Further, the clinical guidelines must be disseminated to providers, reviewed and updated on a regular basis, and the MCO must ensure that the guidelines are used for utilization management, Enrollee education, and other areas. The MCO must also audit provider compliance with the guidelines and report progress to DHS in its Quality Assessment. State law supports the use of clinical guidelines and mandates that guidelines be provided to patients upon request. *Minnesota Statutes, § 62Q.735, 62M.072 and 62M.10*. These contract requirements would continue under the demonstration.

Minnesota is fortunate to be the home base of the Institute for Clinical Systems Improvement (ICSI), a non-profit organization to which all DHS MCOs and many providers belong and contribute. In addition to condition-specific acute care guidelines and clinical efficacy reviews, ICSI and its members provide guidelines, order sets, and protocols related to a variety of patient safety issues in the inpatient and outpatient care setting. Care that is highly relevant to the elderly population, for example, is addressed in the protocol for fall prevention, or that for palliative care which are available to all plans and providers.

Additional DHS contract provisions involving evidence-based care are included in Article 7, Quality. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, including the CMS “Quality Framework for the Elderly Waiver” and current NCQA “Standards and Guidelines for the Accreditation of Health Plans.” This evaluation must review the impact and effectiveness of the MCO’s quality assessment and performance improvement program including performance standard measures and the MCO’s performance improvement projects. The evaluation must also include an analysis on the impact and effectiveness of Care Coordination activities. DHS’ expectation for quality reporting is that, where applicable, the MCO report its findings and progress in statistically valid and reliable format. Further details are in Sections 7.2 and 7.3 of the 2012 contract, which would be carried over into the dual demonstration contract.

In addition, current SNPs and MCOs are working with numerous local and statewide efforts to encourage evidence-based practices.

## **L. Benefit Design**

Minnesota provides a comprehensive array of State Plan and LTSS waiver services under its current Medicaid benefit. Pending negotiations with CMS on the financing model, the State intends to have the HCH benefit included in base costs for Medicare. Other benefits will be consistent with current Medicaid benefits or any changes in those benefits that may occur between now and the end of the demonstration based on other reform activities or legislative changes. There are State policy differences in the benefit designs of managed care programs for seniors age 65 and older compared to people with disabilities age 18-64. See Article 6 in each contract for a list of current covered benefits.

### **Seniors**

The State would include current Medicaid benefits as provided under MSHO in its capitation. This includes State plan services including mental health services, all home and community long term care services and supports and carefully designed nursing home benefits. While not all nursing home per diems are included in the capitation rates, all nursing home members are enrolled and receive all other benefits including primary care, Part D and other pharmacy benefits and care coordination through the plan. Nursing home members remain enrolled regardless of whether the nursing home per diem benefit is paid through Medicare, Medicaid fee-for-service or the SNP/MCO under its capitation rate. The current long term care benefit design has proven successful in avoiding long term nursing home stays. The State will be pleased to provide further detailed information on the rate setting process for this benefit during the MOU development process as necessary.

Under the demonstration, the State would continue existing features of these programs including integrated care coordination across Medicare and Medicaid primary, acute and long term care, assignment of individual care coordinators, fully integrated member materials, initial and comprehensive health risk assessments, and assessment and management of LTSS including provision of Money Follows the Person (MFP) and consumer directed options. Other features to be continued would include collection of full encounter data, submission of assessment data to the State's MMIS system, integrated member services, 24/7 nurse lines, and other current contract requirements.

### **People with Disabilities**

For people with disabilities, current Medical Assistance benefits would remain the same as those capitated under SNBC with the same proposed change in HCH and the potential inclusion of a targeted Medicaid Health Home benefit as described in Model 3. Integrated features such as care coordination and navigation across covered Medicare and Medicaid benefits, fully integrated member materials, initial health risk assessments, coordination with LTSS and Money Follows the Person and other consumer directed options, collection of full encounter data, submission of assessment data to the State's MMIS system, integrated member services, 24/7 nurse lines, and other current contract requirements would continue under the demonstration.

Further negotiation with CMS would be needed around CMS requirement to include long term care services and supports under capitation for this group. While SNBC includes all home health aide and skilled nurse visits as well as 100 days of nursing home care for newly placed community based enrollees, current DHS policy does not provide for capitation of LTSS including Intermediate Care Facilities for People with Intellectual or Developmental Disabilities (ICF/DD), personal care, private duty nursing and four 1915(c) waivers for LTSS applicable to people with disabilities age 18-64. However, all members remain enrolled in the plan including nursing home and ICF/DD residents and all other services continue to be managed through the plan. Members can receive the non-capitated benefits through fee for service and the plan is required to assist them with access and coordination with these services. Several other CMS demonstration contract States also share this issue, and CMS has said it may consider allowing "virtual integration" models with "shared accountability" under fee-for-service arrangements in lieu of full capitation of long term care services and supports.

As CMS may be aware, Minnesota has achieved a remarkable level of "rebalancing" for people with disabilities on Medicaid, having drastically reduced institutional utilization in the 1980s and 1990s. Over 95% of dually eligible people with disabilities are served in their own homes or small residential community settings; 33.7 % of these individuals receive waiver services and another 9% receive personal care services in the community. Less than 5% of dually eligible adults eligible to enroll in SNBC reside in institutional settings (about half in nursing homes and half in ICF/DD settings) and over 50% of the nursing home stays are less than 90 days. The State is in the process of implementing the CMS Money Follows the Person initiative. The state also provides numerous consumer directed

options. There is little chance of cost shifting to institutional care for this population in Minnesota. In addition, waiver services are managed by counties that are already essentially operating under capitated arrangements set by the State through a risk adjusted allocation methodology that caps total budget and waiver slots.

The current challenges for improving care for people with disabilities do not require capitation of already capped and often consumer directed long term services. The State has experience with capitating waiver services for this population and found it highly complex. Stakeholders have expressed many concerns about capitation of personal care and other LTSS services. The complications involved in transferring this function from counties to health plans and fully capitating four specially designed home and community based waiver programs would not be worth the immense work this would require and would have no impact on retaining people in their homes, since this is already the norm for care here in Minnesota. Instead for this population, we want to focus on problems that require more immediate attention such as inefficiencies in utilization between Medicare benefits and Medicaid state plan services where lack of integration of these services is truly a barrier to better care. For example, people with mental illness or people with physical disabilities may be hospitalized for underlying chronic conditions that are poorly managed due to lack of an ongoing relationship with a primary care physician, or may seek treatment in emergency rooms for similar reasons and may have poor transitions back to the community due to lack of communication between primary care providers and LTSS or mental health providers.

Unlike some other states, Minnesota already includes all Medicaid behavioral, substance abuse and mental health benefits under managed care capitations including targeted mental health case management. SNBC plans are required to coordinate with LTSS even though they are not directly responsible for providing those services. The State has several innovative pilot projects for co-location of mental health and physical health professionals and these efforts would be greatly enhanced by integrated Medicare and Medicaid primary care financing. Allowing the State to take a stronger role in alignment of Medicare and Medicaid primary care could help to improve access to primary and preventive care, ensure smooth transitions between acute, post-acute, mental health and home health services and LTSS, and increase incentives for better integration of physical and mental health services.

Therefore, assuming a viable financial model can be agreed upon for this population, the State proposes a shared accountability model for the SNBC eligible population. To address CMS concerns for accountability and to protect against cost shifting under the shared accountability model, the State would consider mechanisms below as additional safeguards:

- Requiring MMICOs and LTSS coordinators to coordinate in specific ways (several SNBC plans already utilize county LTSS case managers to provide care coordination).
- MOUs between counties, HCH or ICSPs and MMICOs with contract requirements for development and implementation of mechanisms to address outcomes with measurable results on key transitions or utilization issues.
- Encouraging HCH providers and residential facilities for people with disabilities to develop partnerships under the purchasing models above.
- Protocols for residential providers to follow a short screening procedure prior to calling 911 coupled with access to clinical resources for provider consultation
- Metrics for evaluation of outcomes around high leverage areas where cost shifting could occur such as hospitalizations rates for nursing home and ICF/DD members, and hospital utilization rates for people in residential settings such as adult foster care or assisted living facilities.
- Shared savings models with providers could be explored; such models could be pursued for services delivered outside of capitation based on provider effectiveness measures.

### **M. Financing and Savings Model**

Since both proposed populations are already enrolled in managed care arrangements, the State is pursuing the capitated financing model as outlined in our Letter of Intent submitted on October 1, 2011 in response to the July 8, 2011 CMS State Medicaid Director's letter.

Both the State and CMS are conducting analyses of current Medicare and Medicaid costs to determine a viable model for integrated financing for the dual demonstration. Medicaid and Medicare rates would continue to be based on separate methodologies but would be considered as one total capitation for savings projections and would be fully integrated at the plan level. CMS requires that savings be achieved under the demonstration and that it can be shared with the State. They also require a performance based withhold of 1, 2 and 3% respectively for years one, two and three of the demonstration. (Minnesota already requires a Medicaid withhold.) DHS proposes to align and combine the Medicare and Medicaid performance based withholds to the extent possible within current statutes with any new measures to be determined under the three-way contracting process.

While CMS has set some broad parameters for the MOU and the financing model, few details have been provided as yet so it is still unclear whether a viable financing arrangement can be negotiated. CMS has agreed to continue to work with the State to review its data and address concerns raised by current health plans about the financing model.

The State faces a number of challenges in negotiating a viable financial model with CMS. Medicare county payments vary considerably across the nation and Minnesota's payments are generally below the national average. Planned cuts in Medicare Advantage payments would likely flow through to demonstration plans. While Congress may restore the sustainable growth rate (SGR) cuts to physicians, this positive change usually does not flow through to Medicare capitations and it is unclear how this will be incorporated into the demonstration. With Minnesota's 15-year history of integrated Medicare/Medicaid programs, there are likely to be fewer Medicare savings for most seniors. Experience for people with disabilities under Medicare D-SNPs indicates that new enrollees have a host of unmet health needs in the first years of enrollment and that Medicare risk adjustment does not adequately address new enrollee costs.

CMS has acknowledged that Minnesota's situation may be different from other states, and expresses willingness to explore solutions as part of the negotiation process. A viable financing arrangement must be reached for the three-way contracts with the State and the MMICOs before the demonstration can go forward.

### **N. Payments and Rates**

Further information on MMICO and provider payment arrangements to be implemented under Models 2 and 3 in Section K will be developed prior to implementation, based on negotiations with CMS and MMICOs around the financing and savings models. Methods will be based on learning and experience from current MSHO care system contracting arrangements as well as HCDS arrangements currently under negotiation. Medicaid payments to MMICOs are expected to continue to be paid by the State with CMS making Medicare payments directly to the MMICOs. Medicaid rates for MMICOs are expected to remain similar to current rate setting methods. Medicaid rates must continue to reflect any required legislative and policy changes occurring during the demonstration. The State has a specialized risk adjustment system for Elderly Waiver services, and uses the Chronic Illness and Disability Payment System (CDPS) for SNBC which is expected to remain in place. The State's actuary will provide additional analysis for the payments under the dual demonstration. The State requests that CMS apply its proposed Medicare HCC risk model improvements to the demonstration, including the proposed change for dementia and the increase in number of conditions considered under the model, both of which MedPAC has already recommended to Congress for implementation.

The State is particularly concerned about the coordination of Medicaid rate setting processes for people with disabilities with the CMS Medicare rates for people with disabilities. As noted earlier, the State has had five SNPs serving people with disabilities drop out of Medicare Advantage over the past several years. The State now includes a risk and gain sharing corridor arrangement in all SNBC contracts for non-SNP enrollees including dual eligibles. This mechanism is carefully designed to protect the State as well as the MCO. (See Section 4.1.2 of the SNBC contract.) We request that CMS apply this risk and gain sharing plan to the entire integrated rate setting process for all people with disabilities enrolled under this demonstration. This will be necessary to incent MMICOs to participate in Medicare and to enroll people into the demonstration. Since current MCO/SNPs participating in SNBC

have access to this risk corridor protection under Medicaid it must be reflected in the demonstration design in order to achieve adequate plan and provider participation. In addition, we request that CMS consider utilizing the CDPS risk adjustment model for both Medicare and Medicaid services for this population. The CDPS risk adjustment model is specifically designed for people with disabilities and has a more inclusive diagnostic algorithm than CMS' current Medicare risk adjustment system. The State is considering rebasing CDPS weights so CMS could work with the State to assure that weights are appropriate for both Medicare and Medicaid services. If the State's CDPS system is not utilized, the State requests that CMS implement the new enrollee Medicare HCC risk model improvement which was found to be important for C-SNPs as studied by the General Accounting Office.

#### **O. Measurement, Evaluation and Outcomes**

Currently D-SNPs are required to collect and report measures specified by CMS Medicare, CMS Medicaid, the Minnesota Department of Health (MDH), and DHS contracts. These measures do not always capture the most relevant outcomes for populations with special needs. This demonstration presents an opportunity to prioritize, integrate and streamline overlapping Medicare and Medicaid requirements as well as to employ measures that are important for dually eligible populations such as those related to long term care, quality of life and self-management. The State would also identify measures to be applied to provider care systems consistent with federal, state and community measurement efforts and adjusted as necessary to apply appropriately to enrolled dual eligibles, including those using LTSS and/or mental health services.

Minnesota is home to a host of innovative and collaborative quality assurance and outcome measurement activities being implemented across the state by various coalitions of providers, health plans, State agencies and others in which current plans serving seniors and people with disabilities are participating. Because dual eligibles are a very small population and providers may often serve only a small number of them, these initiatives do not necessarily focus on measures and outcome goals most relevant to dual eligibles. However, it is important to attempt to align with these efforts to avoid burdens and conflicting expectations for plans and providers.

CMS has already announced that they have chosen RTI working in conjunction with a number of subcontractors, as their contractor for the formal evaluation and evaluation measures are already being developed. Other federal efforts through the National Quality Forum are underway to identify more appropriate measures for dually eligible beneficiaries. The State expects to cooperate with these efforts. However there is concern about whether information about required measures for the evaluation and for new measures from NCQA will be available in time for development of the three way contracts under the demonstration.

The challenge for the State will be to reconcile all of the various State, Federal and community measurement initiatives so that they are aligned with other initiatives such as the MAPCP and HCDS, but are also appropriate for duals and not overwhelming to MMICOs, ICSPs and providers. Because most seniors have been enrolled and managed in integrated Medicare/Medicaid programs for some years an additional challenge to the State will be identifying realistic attainable measures that have not already been addressed and /or achieved.

The State is in the process of hiring a consultant to assist in conducting analysis and review of these applicable initiatives to identify areas in which the State could best focus efforts for the dual demonstration. Recommendations from this process will be available prior to the implementation of the demonstration but are also contingent on the financing agreements under the demonstration.

#### **Expected Outcomes**

Until there is more available information about the viability of financing models under the demonstration, it is difficult for the State to propose specific outcome measure targets for dual eligibles who may choose to be enrolled. Because most seniors have been enrolled in integrated Medicare Medicaid programs for some years, some utilization reductions have already been achieved (see Section V Barriers). Some utilization rates for people with disabilities enrolled in SNBC also indicate improvements when compared to fee-for-service, but the influx of many new members under the expansion will require re-establishment of utilization benchmarks.

At minimum the State would continue to expect high satisfaction and low disenrollment of consumers under this demonstration as well as continued improvement in selected HEDIS measures. However, within the Triple Aim framework, there is more that can and must be achieved if these programs are to be sustainable. Using the

integrated dual data base currently being developed, the State intends to explore variations in key utilization rates between providers, populations and population subgroups, and regions to develop a more targeted approach to utilization improvements and measurements.

The State does expect to address further reduction of avoidable hospital admissions under this demonstration. The State will build on the RARE (Reducing Avoidable Hospital Readmissions Effectively) initiative to continue efforts to avoid hospital readmissions and to set outcome goals for continued reductions. The Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association (MHA), and Stratis Health, the regional CMS Quality Improvement Organization (QIO) are leading the statewide RARE campaign with managed care organizations including all SNPs, community partners, hospitals and care providers across the continuum of care in order to prevent 4,000 avoidable hospital readmissions in the state and surrounding areas between July 1, 2011 and December 31, 2012. More information is available at <http://www.rarereadmissions.org>.

The State also expects to build on its partnership with Minnesota Community Measurement (MNCM) which works closely with DHS, MDH and commercial purchasers and providers on development and application of standardized measurement and data collection across payers and leads the Aligning Forces for Quality Initiative funded through the Robert Wood Johnson Foundation in which DHS, providers and contracted health plans also participate.

#### **P. Medicare and Medicaid Data, Analytics and Capacity**

The State will utilize a multi-level approach to data analysis, including feed-back data on HCH at the provider and ICSP level consistent with current HCH procedures, analysis of utilization and performance through encounters, analysis of demographic information, and analysis of other performance based information collected by DHS.

The State will continue to collect full encounter data for all Medicare and Medicaid services for enrollees of integrated plans and recently added requirements for pricing information on each encounter. Part D data is also collected but CMS policy precludes including pricing information. The State has access to Medicare data through the MAPCP and is already receiving supplemental Medicare cross-over claim files. The State agrees to share necessary data with CMS as determined under the Memorandum of Understanding (MOU). Since the State already collects all Medicare and Medicaid encounters, the State proposes to share its encounter data with CMS rather than having the MMICOs have to submit data to two different entities in two different formats. However, we understand that direct submission of Part D encounters to CMS would still be required.

The State has previous experience with integrated Medicare and Medicaid data and data use agreements with CMS and has a data warehouse capable of accepting Medicare data. The State is in the process of hiring a contractor for assistance in integrating Medicare and Medicaid fee-for-service and encounter data and providing analytic tools for risk adjustment and standardized measurement for on-going program metrics. The contractor will also assist with necessary data requests to CMS for historical Medicare fee-for-service data and Part D data.

MMICOs will continue to report assessment information including Activities of Daily Living, Instrumental Activities of Daily Living and other demographic information on all community members to the State. The State already has access to Minimum Data Set information for residents of nursing homes.

The State intends to utilize its existing HCH provider feedback system for ongoing monitoring of HCH provider performance, along with regular monitoring and analysis of utilization through MMICO priced encounter data and other performance related information such as denial, termination and reduction notices which must be reported to DHS, appeals and grievances, member satisfaction (Consumer Assessment of Healthcare Providers and Systems or CAHPS), care plan and care system audit reports, required Healthcare Effectiveness Data and Information Set (HEDIS) measures, Minnesota Department of Health audits, quality/performance improvement projects, required financial reporting, waiver services reviews, and other Medicaid requirements.

#### **Q. Enrollee Protections**

Minnesota has an extensive and long-established system for assuring managed care enrollee rights and protections. The system is codified in statute and is reflected specifically in current managed care contracts, which would be carried forward to the dual demonstration contracts. All HIPPA and state requirements related to individual data

privacy and communication of private and protected information are included. These enrollee protection requirements are outlined in current contracts as well as in other operational processes followed by the State. Citations would be too numerous to list separately so a summary of key areas is provided below.

Contracts contain requirements for involvement of members and care givers in care planning, including care-giver assessments (Seniors) and partnerships with the enrollee and/or their designee as well as consumer education on self-management (SNBC). Seniors contracts (which capitate LTSS) also include requirements that members are informed of all consumer directed options and may choose their care setting and providers and may appeal if they disagree with care provided to them.

The SNBC contract also includes a requirement (also in Minnesota Statutes 256B.69 subdivision 28) that each SNBC plan maintain a local stakeholders group. SNBC plans submit documentation to the State each year on details of this group including meeting agendas and minutes and results of follow up to address any concerns expressed. While the MSHO/MSC+ programs also have advisory activities that include members and or family members, the State intends to amend the senior's contracts to include a similar provision as part of this demonstration.

Contracts require collection of primary language on enrollment forms with follow up calls to members to determine language preferences, access to materials in alternative formats, access to oral interpretation or language specific member materials, notation of non-English speaking providers in provider directories, access to culturally appropriate care providers, additional coordination and out of network services for American Indian members. In areas where there is extensive cultural diversity, D-SNP/MCOs typically hire or contract with care coordinators, navigators and member services staff who speak Somali, Spanish, Hmong and/or Russian, Minnesota's largest non-English speaking populations. In addition SNBC plans must provide training to customer services staff about special needs of SNBC members and all SNBC plans have collaborated on a periodic access survey of providers on the physical accessibility of primary care clinics and dental offices (2012) which is made available to enrollees. D-SNP/MCOs with significant numbers of ethnically diverse members are also highly involved with local cultural communities, sponsoring health literacy programs, health fairs, and other education and support activities.

Contracts currently include continuity of care and transition requirements for plans to provide the same services with the same providers for medical care that the new enrollee was using before enrollment, as well as providing all services prior authorized by a previous plan; medications previously used; and mental health services previously used. This includes approval of a standing referral to a specialist if the specialist is in the position of providing the enrollee's main care. The State proposes to apply these transition protections to Medicare benefits if such protections are not already included

An additional feature to be established in the dual demonstration contract is further protection against changes in medication access due to Enrollee changes in Medicare Part D coverage. DHS expects to ameliorate negative effects on enrollees due to formulary differences and changes. This will be in addition to the protections inherent in the Part D manual.

The State has an extensive grievance and appeals system allowing an enrollee to appeal to MDH, DHS or the health plan and to appeal directly to the State for a State Fair Hearing without having to go through the health plan. Notices of all appeal and grievance and State Fair Hearings rights are provided to members periodically with information on how to appeal and how to contact the State Managed Care Ombudsman Office for assistance if needed. Specially trained Managed Care Ombudsman staff are available to assist enrollees with resolving their concerns or submitting a grievance or appeal. These ombudsmen also coordinate with the State Long Term Care Ombudsman, and the State Ombudsman Office for Mental Health and Developmental Disabilities. The State is also experienced in coordinating Medicare and Medicaid appeal rights which CMS has indicated can be further integrated under the demonstration, which should help to reduce confusion for enrollees. The State has a long standing integrated appeals and grievance protocol for SNPs which will meet requirements for both Medicare and Medicaid under the demonstration. Copies of the summary version along with a more detailed version are included at Appendix 2. Additional detail on these rights is provided in Article 8 of the contracts below.

[http://www.dhs.state.mn.us/dhs16\\_166538.pdf](http://www.dhs.state.mn.us/dhs16_166538.pdf)

[http://www.dhs.state.mn.us/dhs16\\_166539.pdf](http://www.dhs.state.mn.us/dhs16_166539.pdf)

The State also collects, tracks and analyzes grievance and appeal information as well as information about all denials, terminations and reductions in service (DTRs). Currently the DTR notices are very long and complex as they must include Medicare required statements as well as Medicaid required statements. Under the demonstration, the State would like to work with CMS to find a way to shorten and simplify these notices while ensuring that the enrollee is provided information needed to appeal.

In addition, the State conducts a program specific CAHPS (Consumer Assessment of Health Providers and Systems) survey each year and reports detailed information on results with areas of performance and needed improvement to the plans and the public. While D-SNP sponsors are also required to conduct CAHPS they are not required to conduct this at the D-SNP level so information is not always relevant to dual eligible programs. The State requests that its own CAHPS survey (which meets all AHRQ and CMS CAHPS requirements) be utilized in place of each plan having to continue to conduct duplicate surveys.

#### **R. Legislation Required or Medicare and Medicaid Waivers Requested**

The State has existing legislative authority for integrated Medicare and Medicaid managed care demonstrations and managed care enrollment for these populations. No additional authorities required for the demonstration to move forward have been identified. The State is not aware of any additional Medicaid waivers that would be required for implementation of this demonstration at this time. However, if other Medical Assistance reforms require CMS waivers applicable to these populations affecting access or benefits, there may be interactions or impacts on current authorities that require adjustments. Since information on other Medical Assistance changes that may occur in 2012 legislation or that may be required due to CMS demonstration issues that arise from further CMS guidance is not yet available, the State proposes that such Medicaid changes be handled through the MOU to be negotiated between CMS and the State.

CMS has provided documents outlining additional Medicare flexibilities they are willing to entertain as part of the dual demonstrations contracting process. The State is preparing a list of technical and operational integration issues that will need to be addressed as part of the demonstration MOU to ensure that care coordination requirements, member materials, enrollment processes, notices, benefit determinations, audit criteria, quality assurance requirements, member services, and other contract requirements remain integrated and that members continue to experience seamless Medicare and Medicaid access. In addition, the State hopes to be able to streamline and simplify additional operational requirements to reduce administrative burdens and costs.

In particular, the State requests that current approved SNP Models of Care (MOC) be transferred to the demonstration. All current plans have received multi-year approvals for their MOCs with all but one receiving a three-year approval. These MOCs already incorporate the State's requirements for care coordination under Medicaid. For 2014 the State would also suggest that MOC provisions be modified to accommodate rural areas and virtual interdisciplinary team communication methodologies. The State would like to work with CMS through the MOU on additional streamlining of other reporting requirements that it will specify during the MOU development process.

Given the uncertain nature of the demonstration's Medicare financing arrangements, the State is concerned about the potential for SNPs to transition back to SNPs status if the State, CMS or the MMICOs cannot reach agreement on demonstration parameters or if unexpected barriers to implementation or continuation of the demonstration should arise. The State requests assurances from CMS that it would facilitate transitions of demonstration plans back to SNP status to avoid disruptions in long standing integrated care arrangements for beneficiaries in the event that there is agreement among all parties that the demonstration is not viable.

#### **S. Relationship to Existing Waivers and Service Delivery Initiatives:**

##### **a) Medicaid Waivers and State Plan Services**

Current managed care programs for seniors are operated under 1915(b) (c) for MSC+ and 1915 (a) (c) for MSHO. Under the demonstration they would continue to operate under those authorities and would continue to provide the same State Plan and waiver services. SNBC for people with disabilities is also operated under 1915(a) and would also continue to operate under that authority. Other than a few groups excluded from managed care enrollment for technical reasons, there are no major population carve outs under any of these programs. Benefits covered would also remain the same unless changed as a result of other State initiatives as described below. The State is proposing one benefit change related to Health Care Home payments as described

earlier. Operating requirements for participating MMICOs are outlined in current contracts which would be retained with necessary modifications to accommodate the goals of this demonstration as agreed upon with CMS and the MMICOs and are incorporated into this proposal by reference through the links provided.

**b) Existing Managed Care Programs**

As described earlier, the State has several existing programs for dual eligibles. Both seniors programs enroll people in all settings of care. All State Plan (including mental and behavioral health service) and 1915(c) services currently included under those current managed care/managed long term care programs would continue to be included under the demonstration. The same people currently served under those programs would continue to be enrolled under the demonstration under new arrangements with MMICOs. The State no longer operates a managed long term care program for people with disabilities and lacks authority to do so under a capitated arrangement. However, the State is proposing a shared accountability model for this population in lieu of full capitation. (See Section L)

**c) Behavioral Health Plans**

All behavioral health services offered under the State Plan are included in managed care capitations for all populations so there are no free standing behavioral health plans in Minnesota for Medicaid enrollees. A special initiative operated under SNBC for people with SPMI, the Preferred Integrated Network (PIN), is a partnership between Medica and Dakota counties designed to integrate physical and mental health. The State would propose to continue this initiative and build upon it under the demonstration.

**d) Integrated SNP or PACE programs**

The State is proposing that current contracted D-SNPs become MMICOs and operate under the demonstration and that current enrollees be seamlessly transitioned into the new integrated demonstration plans. The State issued an RFP for PACE providers in 2011, however there were no respondents so there are no PACE programs in operation in Minnesota.

**e) Other State payment/delivery efforts underway**

As previously described, the State intends to incorporate HCH, HCDS and other Medicaid purchasing, payment and delivery system reform models within the capitated financing provided under the demonstrations. Further, the State is pursuing a number of potential changes under the MA Reform initiative related to services for seniors and people with disabilities. Some of these re-design efforts could result in additional waiver requests to CMS in the coming months, which could lead to modifications to services provided under the demonstration, but would not prevent the demonstration from moving forward. Specific information is not yet available on these potential changes but can be shared with CMS when available. The State will provide any data on state supplemental payments such as DSH and UPL as required by CMS during the demonstration.

**f) Other CMS Demos**

**MAPCP:** Minnesota is an all payer HCH state and one of eight participants in the MAPCP demonstration. However the MAPCP demonstration provides health care home payments only to Medicare eligibles enrolled in fee-for-service. Under this demonstration the State requests that health care home payments be made through Medicare for dually eligible demonstration participants. Medicaid currently covers HCH payments for dual eligibles under the State Plan but since Medicare is primary for primary and acute care services, this should be a Medicare covered service for dual eligibles enrolled in managed care systems.

**T. State Infrastructure and Oversight**

DHS is the State Medicaid agency in Minnesota and the sponsor of this demonstration. Other agencies involved in oversight include the Minnesota Department of Health (MDH) which licenses, certifies and audits risk bearing entities (HMOs and county based purchasing (CBP) entities) participating in the State's managed care programs and the Minnesota Department of Commerce, which oversees insurers and financial compliance for HMOs and CBPs.

Within DHS, primary leadership responsibility for the demonstration lies within the Health Care Administration (HCA) under the direction of Assistant Commissioner Scott Leitz and Medicaid Director David Godfrey, working in coordination with Assistant Commissioners Loren Colman (Continuing Care) and Maureen O'Connell (Chemical and Mental Health).

Since the State currently operates managed care programs for seniors and people with disabilities which are expected to transition to demonstration status, DHS will continue to employ current resources to implement and oversee the dual demonstration in addition to a modest budget request as provided for implementation assistance by CMS. These include the following:

Within HCA, under the Purchasing and Service Delivery Division (PSD) led by Mark Hudson, Director, a number of units are involved including the PSD Compliance unit which develops contracting policy, provides a contract manager to oversee each plan and oversees MCO compliance with all contract requirements, the PSD Operations unit which manages all enrollments, and the Special Needs Purchasing (SNP) unit, which develops and coordinates rates and policy for contracts for seniors and people with disabilities. Also within HCA, the Performance Measurement and Quality Improvement Division develops and oversees performance measurement and contract quality requirements, leads health disparities work and administers an interagency agreement with MDH for additional auditing and financial oversight of plans, the Office of Medicaid Director and contract unit interprets and applies federal Medicaid policy including managed care policy and oversees the development and execution of managed care contracts, the Managed Care Ombudsman Office assigns specially trained staff to work on concerns brought forward related to managed care programs for seniors and people with disabilities, and the Medical Director oversees medical policy for the Medicaid program. Additional support is provided by the State's Senior and Disability Linkage Lines, part of the State Health Insurance Program housed in Continuing Care, who are available to enrollees to provide consumer choice counseling assistance around Medicare choices including interface with Part D. In addition, managed care programs coordinate closely with the Continuing Care Administration policy staff including the Aging Services and Disability Services Divisions, which manage State Plan home care and home and community based waiver policy for seniors and people with disabilities and the Chemical and Mental Health Administration policy staff which manages policy for populations requiring those services.

Two positions funded under the CMS design contract are assigned to implementation and management of the demonstration. The management structure for the demonstration includes work teams that lead the design and implementation. These include the HCA Leadership Work Team, the Interdivisional Work Team, the Demonstration Work Team, a Data Work Team and others as needed. Teams involve the Medicaid Director's office, the Medical Director, staff involved in implementing HCDS and HCH programs and subject matter experts from Aging and Disability Services and Mental and Chemical Health as well as current managed care staff assigned to managed care contracts for seniors and people with disabilities.

#### **U. Summary of Stakeholder Involvement**

The State has conducted extensive efforts to involve affected stakeholders in the demonstration development process. A public website for the dual demonstration was established and materials and meeting schedules have been posted regularly. Two overarching external stakeholders groups were established; one for each population group, seniors and people with disabilities. Since the State has been expanding enrollment for people with disabilities into managed care and the two activities are linked, the demonstration stakeholder process was combined with the expansion stakeholder process. Five large highly attended meetings have been held thus far for people with disabilities with an additional five subgroups established with twelve subgroup follow up meetings and another nine for enrollment outreach. Three large group meetings have been held for seniors and an additional four public presentations have been held. In addition the State has had five meetings with current managed care plans to discuss the demonstration, including a call with CMS with more meetings scheduled. The State has also made an additional 12 presentations to community and provider groups about the demonstration and continues to solicit broad input from the community. See stakeholder meetings documentation below.

These stakeholder activities will continue. The Seniors' and Disability Stakeholder groups will continue to meet quarterly throughout the demonstration, with smaller subject matter breakout groups as jointly determined by the groups and DHS. MMICO stakeholders will continue to meet at least monthly. Additional informational meetings will be held for interested providers in conjunction with the ICSP development and negotiations process. In addition, DHS will continue to make presentations to interested community and provider groups. Currently each SNBC plan is required by State law to maintain a local Stakeholder's Advisory Committee which meets at least quarterly and reports proceedings of these meetings to DHS. Under the demonstration, seniors contracts will be amended to require that all MMICOs to maintain these groups.

Several tribes in Minnesota are also active in providing care coordination and home and community based services to dually eligible members. The State has included tribal entities in discussions about this dual demonstration and the SNBC expansion and will continue regularly scheduled focused stakeholder group discussions with the tribes as the demonstration proceeds including facilitated discussions with the MMICOs.

Throughout this process DHS has and will continue to make materials available in alternative formats upon notification of such needs. Materials are also posted on the special website established for the demonstration.

### **Documentation of Dual Demo Stakeholder Meetings**

#### **Stakeholder's Meetings for People with Disabilities in Managed Care**

- Initial Stakeholder Meeting: August 30, 2011
- Managed Care 101 Training Initial Meeting: November 4, 2011
- Statewide Videoconference: December 8, 2011
- Stakeholder's Meeting for People with Disabilities in Managed Care
  - January 27, 2012
  - March 2, 2012

#### **Seniors Managed Care Stakeholders Group**

- December 9, 2011
- January 27, 2012
- March 2, 2012

#### **Managed Care for People with Disabilities Outreach/Education**

- September 29, 2011, Disability Linkage Line Staff - in person
- September 29, 2011, Region 1, 2 and 3 – webinar
- October 4, 2011, Region 4, 5 – webinar
- October 5, 2011, Region 6, 8 – webinar
- October 7, 2011, Region 7, 11, 10 – in person training
- October 25, 2011, Region 6, 11, 9 – in person training
- October 26, 2011, Statewide – webinar
- October 27, 2011, Statewide – webinar
- February 13, 2012, Mental Health Stakeholders Statewide Video Conference

#### **Focused training/presentation provided upon request**

- August 12, 2011 Continuing Care Partners Panel:
- October 12, 2011 Maxis Mentor Group Video/webinar conference
- October 13, 2011 TBI DHS Policy Subcommittee – in person
- October 20, 2011 Hennepin County Local Mental Health Advisory Council Hennepin County Local Mental Health Advisory Council – in person
- October 20, 2011, Disability Linkage Line MCOs explained 2012 SNBC benefits- in person
- November 5, NAMI conference workshop – in person
- November 3, 2011; ARC Greater Area – in person
- November 17, 2011: ARC West Central – webinar
- December 5, 2011: Commissioner's MA Reform Forum
- December 9, 2011: Continuing Care Partners Panel
- December 13, 2011: Arc Greater Twin Cities and Minnesota Consortium for Citizens with Disabilities – in person
- January 4, 2012: DHS Brain Injury Advisory Committee, in person
- February 7, 2012, County Managed Care Advocates, video conference
- DHS/SSA/DHS Quarterly Meeting, January 18, 2012
- February 8, 2012 Aging Services of Minnesota Annual Conference workshop:

**Initial Topic Focus Stakeholders Workgroup Meetings**

- Children’s Issues Workgroup: Initial Meeting: October 18, 2011
- Care Coordination/Transition Workgroup: Initial Meeting: October 18, 2011
- Managed Care 101 Training: Initial Meeting: November 4, 2011
- Consumer Education, Outreach, and Marketing: November 8, 2011
- Evaluation Subgroup Initial Meeting: January 19, 2012

**Follow Up Meetings of the above Topic Focus Stakeholder Workgroups**

- Children’s Issues Workgroup: Tuesday, November 15, 2011
- Consumer Education, Involvement and Outreach: February 16, 2012
- Evaluation: Scheduled for April 2012

**Care Coordination and Transitions**

- Durable Medical Equipment (DME)
  - December 16, 2012
  - December 21, 2012
  - January 18, 2012
  - April 18, 2012

**MH-TCM: TBD****MCO/CTY/Tribe Waiver Communications**

- Tuesday, November 15, 2011
- January 6, 2012
- February 24, 2012

**V. Feasibility and Sustainability****Discussion of Barriers to Implementation**

Minnesota’s long experience in managing within aligned Medicare and Medicaid financing has already produced increases in primary care visits, and reductions in re-hospitalizations and improvements in other health outcomes as well as high satisfaction rates on CAHPs surveys. The MSHO program has been operating for over 15 years. Finding additional significant savings in these long standing programs will be challenging as the “easy” savings may have already been achieved. AARP recently ranked Minnesota’s long term care system number 1 in the country. Within the past 10 years Minnesota has “rebalanced” its institutional versus community based care for seniors with 60% of all seniors qualifying for long term care or personal care services served in the community. (Rebalancing for people with disabilities was accomplished years before that.) Ninety-eight percent (98%) of MSHO seniors have an annual primary care visit. MSHO showed reduced hospitalization rates for Ambulatory Care Sensitive Conditions (ACSC) for asthma, bacterial pneumonia, congestive heart failure, dehydration and diabetic complications between 2006-2009 (most recent data available). MSHO satisfaction scores are the highest among all of the State’s managed care programs, and while enrollment remains voluntary, dis-enrollment is <3%. SNBC also performed better than fee-for-service on six key HEDIS measures including preventive visits and voluntary disenrollment rates prior to the enrollment expansion averaged 3%. However, improved measurement tools, continued emphasis on Triple Aim goals and encouragement of new ICSPs will provide new avenues for increasing the effectiveness of care management, and increased provider alignment through the new purchasing models is expected to drive down costs.

While a goal will be to increase integrated provider delivery systems to improve care, costs and outcomes under the demonstration’s integrated Medicare and Medicaid financing arrangements, it is not yet clear how much risk and responsibility ICSP providers will be prepared to assume under these subcontracts. Partnerships will need to include HCH and primary care providers as well as long term care and mental health providers and while some risk/gain based subcontracts are currently in place under SNP we do not yet know how many additional providers are interested in shared risk/gain arrangements across the range of services provided within a fully integrated system. The State will propose flexible arrangements to meet a variety of geographic and sub-population needs, but may need to take incremental steps in developing such systems depending on provider interest.

Further, now that dual eligibles are required to have a Part D plan, enrollment in a Medicare demonstration including Part D services will require MSC+ and most SNBC members to change Part D plans. Enrollment under the demonstration would provide members with integrated pharmacy benefits for Part B, Part D and Medicaid. Members would no longer have to utilize three different cards to access the full range of pharmacy benefits and coverage should be much more seamless. While enrollment under the demonstration should improve the seamlessness of benefit determinations and access, it will also require them to change their Part D coverage, and that can be challenging for beneficiaries.

The State is unaware of additional statutory or regulatory changes required to move forward with implementation, or of additional funding commitments required other than the budget request included in this proposal. Reaching agreement with MMICOs and ICSPs will be required to carry out the goals of the demonstration. The proposal has been designed to be scalable statewide and to be replicable in other States.

#### **W. Implementation and Timelines**

With its long history of managed health care programs for seniors and disabilities, the State already has in place most of the elements required for implementation. However, compliance with very tight CMS timelines will require a very ambitious approach to implementation. The State will issue its annual invitation to contract to current Medicaid contractors with a notice that the integrated contract arrangements will be moving to demonstration status. The State would amend its contracts for current managed care organizations serving seniors in conjunction with the three-way agreement process required under the demonstration and transition current members seamlessly to the demonstration effective January 2013. CMS timelines would require the normal contract process to begin in July with contracts signed by September 20, 2012. We would expect that facilitated enrollment for MSC+ seniors can be conducted as part of the State's normal open enrollment process in the fall of 2012. Because MSC+ also serves non dually seniors and because seniors will not be required to enroll under the demonstration, MSC+ will remain as an option for seniors. For seniors, there should be no immediate significant changes that impact access or services. In the meantime, the State will develop its policies for ICSPs and will plan to issue an ICSP RFP in January 2013, with a planned implementation date of July 2013.

For people with disabilities, implementation is dependent on further negotiations with CMS. However by July 2012 the SNBC enrollment expansion will be largely complete providing a statewide platform for demonstration activities to be implemented before the end of 2013 if agreement is reached with CMS. The State is due to reprocure for SNBC for 2013 and could combine that re-procurement with the CMS demonstration.

#### **Work plan/Timeline Template**

<b>Timeframe</b>	<b>Key Activities/Milestones</b>	<b>Responsible Parties</b>
March 19, 2012	MN Proposal Public Notification with 30-day comment period	DHS
March 19, 2012 – July 31, 2012	Senior population actuarial analysis, rate setting, shared savings and design negotiations with CMS	CMS/DHS Leadership, Actuaries.
March 26, 2012	Issue Request for Proposals (RFP) for SNBC expansion	Procurement Team in Purchasing and Service Delivery Division (PSD)
April 19, 2012	Execute contract for dual data base, data use agreement, and set up for data exchange	Data Team and Legal Counsel.
April 19, 2012	Execute contract for clinical consultant and technical advisor	Legal Counsel
April 19, 2012	SNBC RFP expansion responses due (limited to current contractors)	Procurement team within PSD
April 19, 2012 - April 25, 2012	Review MN Proposal public comments, summarize and final revisions of proposal	Core Dual Demo team, legal counsel and DHS leadership team
April 26, 2012	Final MN Proposal to CMS	DHS Leadership Team
April 27, 2012	Stakeholder's Meeting to discuss MN proposal submission to CMS	Core Dual Demo Team

DRAFT

May 1, 2012	Selection of Successful Responder(s) to SNBC expansion RFP	Procurement Team within PSD
May 1, 2012 – September 1, 2012	Senior Population: develop quality measures and expected outcomes	DHS Medical Director, Performance Measurement, Quality, Improvement (PMQI) division, Aging and Adult Service Division (AASD) and PSD
May 31, 2012	CMS MOU finalized for Senior population including platform for rates and financing	CMS/DHS Leadership Team/legal counsel
June 2012 – December 31, 2012	Platform for SNBC Rates and financing design completed with CMS modeled after Senior Population Design	CMS/DHS Leadership Team, Actuaries
June 1, 2012	For Senior population invitation to contract to eligible MSHO SNPs	PSD and legal counsel
June 1, 2012 - July 6, 2012	Development of Senior population contract changes	CMS/DHS Leadership Team/legal counsel
July 6, 2012 – September 19, 2012	For Senior population 3 way contract negotiations and readiness review requirements met.	CMS/DHS Leadership Team, legal counsel
August 2012	SNBC expansion completed	Procurement Team within PSD
September 2012	Develop job description, post opening, interview and select staff	PSD and HR
September 20, 2012	Contracts for Senior population with MMICOs signed	CMS/DHS Leadership Team
October 1, 2012 – December 15, 2012	Senior population open enrollment. Outreach, marketing and information to beneficiaries, additional CMS readiness review as necessary	PSD policy, Contract Compliance Unit, Managed Care Operations Unit
October 2012 – December 2012	Development of provider ICSP risk/gain models for senior population	DHS Leadership Team, legal counsel, AASD, PSD, Chemical and Mental Health Administration
December 2012 – March 2013	Joint procurement for draft 3 way contract for SNBC	CMS and PSD Procurement Team
January 2013 – December 2013	Contract monitoring and compliance for senior population	Contract Compliance Unit and legal counsel
January 15, 2013	RFP for ICSPs risk/gain models for senior population	PSD Procurement Team
March 15, 2013	Responses for RFP for ICSPs for senior population due and selection of successful responder(s)	PSD Procurement Team
April-May 2013	Contract negotiations for ICSPs for senior population	DHS Leadership Team/legal counsel, MMICOs
April 2013-June 2013	For SNBC population 3 way contract negotiations and readiness review requirements met	CMS/DHS Leadership Team, legal counsel
June 2013	ICSP readiness reviews	MMICOs, PSD policy, Contract Compliance Unit, Managed Care Operations Unit
July 1, 2013	Implementation of ICSPs for senior population	PSD policy, Contract Compliance Unit, Managed Care Operations Unit
July 1, 2013	Implementation of SNBC population demonstration	PSD policy, Contract Compliance Unit, Managed Care Operations Unit
July 1, 2013 – December 31, 2013	Contract monitoring and compliance for senior population including ICSP for senior population	PSD policy unit, Contract Compliance Unit, legal counsel
July 1, 2013 – December 31, 2013	Contract monitoring and compliance for SNBC population	PSD policy unit, Contract Compliance Unit, legal counsel

**X. Interaction with other HHS Initiatives****a) Million Hearts**

The Minnesota Department of Health is working with Minnesota's health plans including D-SNPs, the Minnesota Heart Association and others on a heart/stroke quality improvement initiative. This initiative includes a 2011-2020 State Plan that addresses the goals of the Million Hearts Campaign. The State Plan can be found at <http://www.health.state.mn.us/divs/hpcd/chp/cvh/cvhplan.html>. More information is also available at [www.health.state.mn.us/cvh](http://www.health.state.mn.us/cvh). In addition, we understand that CMS has announced that this will be a Chronic Care Improvement Program topic for Medicare Advantage plans including D-SNPs in the future. In addition, D-SNPs successfully implemented an aspirin therapy QIP for seniors that has been incorporated into ongoing protocols.

**b) Partnership for Patients**

Minnesota's D-SNPs have participated in the Partnership for Patients CMS trainings and are already working on the State's RARE initiative mentioned earlier which focuses on reducing re-admissions. One of the CMS required Quality Improvement Projects for SNPs is Reducing Re-admissions, so D-SNPs in Minnesota are currently working on how this could be designed. Important to this effort is continuation of the transitions work begun under the D-SNP Collaborative discussed in Section K.

**c) HHS Disparities Action Plan**

The Minnesota Department of Health is the lead agency in Minnesota working on eliminating health disparities and sponsors a number of initiatives as well as comprehensive long range planning efforts to eliminate health disparities. Health plans and DHS participate in their stakeholder group on eliminating disparities. Their work is aligned with the goals of the HHS Disparities Action Plan. More information is available at <http://www.health.state.mn.us/ommh/publications/legislativevpt2011.pdf>. DHS also sponsors a workgroup on collection of race, ethnicity and language data which works in conjunction with MDH and Minnesota Community Measurement. The State's managed care contracts require that the plans cooperate with this effort to retain and apply race and ethnicity data supplied by DHS as needed for cross system measurements to measure disparities and related issues. D-SNPs in areas serving ethnically diverse members have also developed extensive Health Literacy programs which will continue under the demonstration.

**d) Reducing Preventable Hospitalizations Among Nursing Facility Residents**

The State has supported provider participation in CMS initiatives for demonstrations to reduce preventable nursing home resident hospitalizations. It is likely that provider sponsors of any approved nursing home demonstrations will be serving dually eligible seniors who could be involved in both demonstrations. The State would like to actively build upon and align with these provider initiatives under the dual eligible demonstration. However should these demonstrations require carving out dual eligibles enrolled under the dual eligible demonstration this could pose complications such as disruption of long standing care coordination arrangements and conflicts with the payment and service delivery reform models being implemented under this demonstration. The State would like clarification from CMS on how the two initiatives could align coordinate and how metrics for the two demonstrations relate or could be sorted out.

**Y. Proposed Budget Request to CMS (Please note this is a very preliminary estimate)**

<b>Budget Period September 2012- August 2015</b>				
<b>Technical /Analytic Support Contracts</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Total</b>
Dual Data Base Development	200,000	200,000	200,000	\$ 600,000
Actuarial (for care system payment development)	<b>50,000</b>	<b>50,000</b>	<b>50,000</b>	150,000
<b>Subtotal Contractors</b>				<b>\$750,000</b>
<b>Staff FTEs</b>				
Project Manager (1 FTE)	90,000	90,000	90,000	280,000
Data Analyst (1 FTE)	80,000	80,000	80,000	240,000
Enrollment Coordinator (1 FTE)	70,000	70,000	70,000	210,000
Policy Coordinator (1 FTE)	80,000	80,000	80,000	240,000
Senior and Disability Linkage Line (2 FTE)	140,000	140,000	140,000	420,000
<b>Subtotal Staffing</b>				<b>\$ 1,390,000</b>
<b>Project Support</b>				
Systems/Data Capacity	25,000	25,000	25,000	75,000
Staff Travel	7,000	7,000	7,000	21,000
Meeting Expenses/Video Conferencing	<b>10,000</b>	<b>10,000</b>	<b>10,000</b>	30,000
<b>Subtotal Project Support</b>				<b>\$126,000</b>
<b>TOTAL</b>				<b>\$2,266,000</b>

**Z. Directions for Comment and Letters of Support****Minnesota Department of Human Services (DHS)****Purchasing and Service Delivery Division****Public Comment Requested: State Demonstration to Integrate Medicare and Medicaid Benefits and Service delivery**

The Minnesota Department of Human Services (DHS) is requesting input from consumers, family caregivers, advocates, providers and other stakeholders on a draft proposal integrating Medicare and Medicaid benefits and service delivery. DHS will release this draft of its proposal to the federal Centers for Medicare & Medicaid Services (CMS) for a Medicare- Medicaid Integrated Financing and Delivery Demonstration under the CMS initiative “State Demonstrations to Integrate Care for Dual Eligible Individuals” after 12:00 noon March 19, 2012 at <http://www.dhs.state.mn.us/dualdemo>. Under this demonstration the State proposes to re-design existing managed care programs for seniors and people with disabilities dually eligible for both Medicare and Medicaid. This proposal is being developed as part of the State’s Medical Assistance reform initiative under Minnesota Statutes 256.021 subd. 4(i). Proposed changes are designed to align incentives between primary, acute and long term care, promote accountability for total costs of care across both Medicare and Medicaid, improve health outcomes, implement provider payment reforms and focus on person centered care coordination to achieve a seamless experience for dually eligible members. This draft proposal builds on a conceptual framework for integrated financing models that was shared with stakeholders on March 2, 2012 and remains a work in progress. DHS announces a 30-day public comment period beginning Monday, March 19, 2012 through Thursday, April 19 2012. Please provide comments on this proposal as soon as possible, but no later than 4 p.m. on Thursday, April 19, 2012. Input from consumers, family caregivers, advocates, providers and other stakeholders is essential to the process and will be used to develop the final proposal that Minnesota will submit to CMS on April 26, 2012.

**Please submit comments and questions via email to: [dual.demo@state.mn.us](mailto:dual.demo@state.mn.us)**

**Written comments may also be mailed to:**

Deborah Maruska  
Purchasing and Delivery Systems  
PO Box 64984  
St. Paul, MN 55164-0984

**Letters of Support Requested**

DHS is accepting letters of support for this proposal, which will be submitted to CMS with the final proposal.

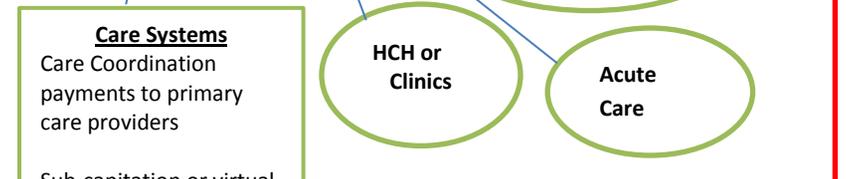
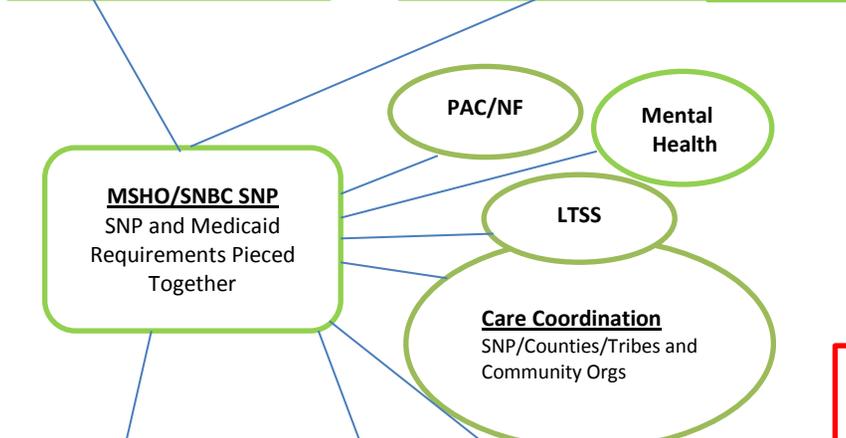
Letters must be received by 4 p.m. April 19.

Please address letters of support to:

David Godfrey  
Minnesota Medicaid Director  
PO Box 64983  
St. Paul, MN 55164-0983

The letters may be submitted by [e-mail](#) at this link, with a signed paper copy sent to Mr. Godfrey at address above. Letters of support must be signed to be considered by CMS. Electronic signatures are also acceptable.

**Appendix 1: Purchasing Model Chart**  
**Current Programs      Aligned Financing**



- Acronyms**
- CD-Chemical Dependency
  - CMS=Centers for Medicare and Medicaid
  - FFS=fee for service
  - HCH=Health Care Home
  - ICSP=Integrated Care System Partnership
  - LTSS=Long Term Services and Supports
  - MMICO=Medicare Medicaid Integrated Care Organization
  - MSC+=Minnesota SeniorCare Plus
  - MSHO=Minnesota Senior Health Options
  - PAC=Post Acute Care
  - NF= Nursing Facility
  - SNBC=Special Needs BasicCare
  - SNP=Medicare Advantage Special Needs Plan
  - SPMI=Serious and Persistent Mental Illness

**Dual Demo Integrated Financing**

3/16/2012

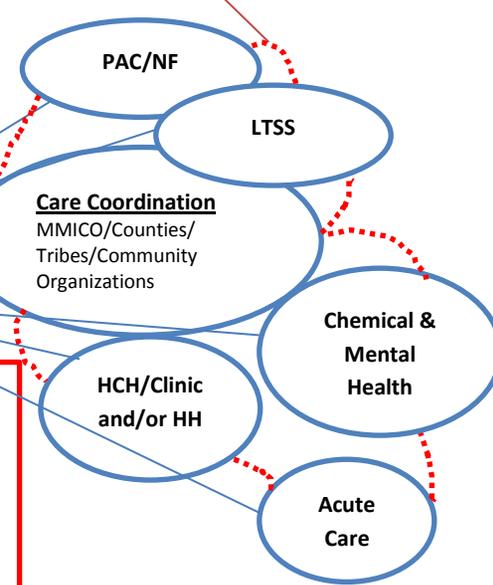
**Integrated Medicaid and Medicare Three Way Contracts and Payments**  
**CMS      State      MMICO**  
 -Shared Medicare Savings with State  
 -Includes Medicare, Part D, current Medicaid State plan and LTSS (seniors)  
 -SNBC LTSS FFS with shared accountability  
 -Seamless transition of MSHO members  
 -MSC+/SNBC members added with opt out  
 -SNBC Phase 2

**MMICO DEMO PLANS**  
 Medicare and Medicaid Integrated Care Organizations Contract Requirements and Risk

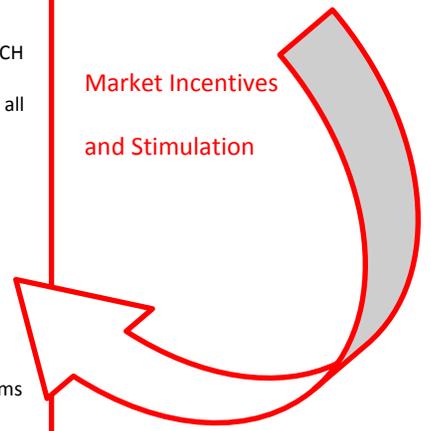
**Model 3: Specialized ICSPs**  
**Mental, Chemical and Physical Health**  
 -DHS establishes criteria for integrated chemical, mental and physical health care system models for people with SPMI enrolled in SNBC under the demonstration  
 - DHS issues RFP  
 -Requires partnership between county, MMICO, primary care, chemical and mental health providers  
 - Could also include non-dual SNBC members  
 -Additional details TBD with Chemical and Mental Health and Continuing Care  
 -Exploring Health Homes and/or HCH as part of model  
 - Standardized outcome measures  
 -Dependent on viable Medicare financing under demo for dual eligibles with disabilities  
 -

**Model 2: Integrated Care System Partnerships (ICSP)**  
 DHS establishes criteria for model options for ICSPs including:  
 -Primary care/payment reforms  
 -Integrated care delivery  
 -TCOC accountability and options for risk/gain sharing arrangements  
 --Opportunities for PAC/NF/LTSS/MH/CD providers  
 -HCH Certification/Transition to HCH  
 -Enrollee choice of ICSP  
 -Incentives to serve people across all settings  
 -Standardized outcome measures  
**New ICSPs**  
 -DHS Issues RFPs to stimulate additional ICSPs  
 -Provider/MMICO Partnership required for response  
 -DHS sets payment and risk/gain options and parameters  
**Existing Care Systems**  
 -DHS evaluates current care systems arrangements, those meeting or exceeding criteria would be considered ICSPs  
 -Transition to HCH if not already HCH  
 -Standardized outcome measures

**Virtual Care Systems**  
 Communication Tools  
**Model 1**



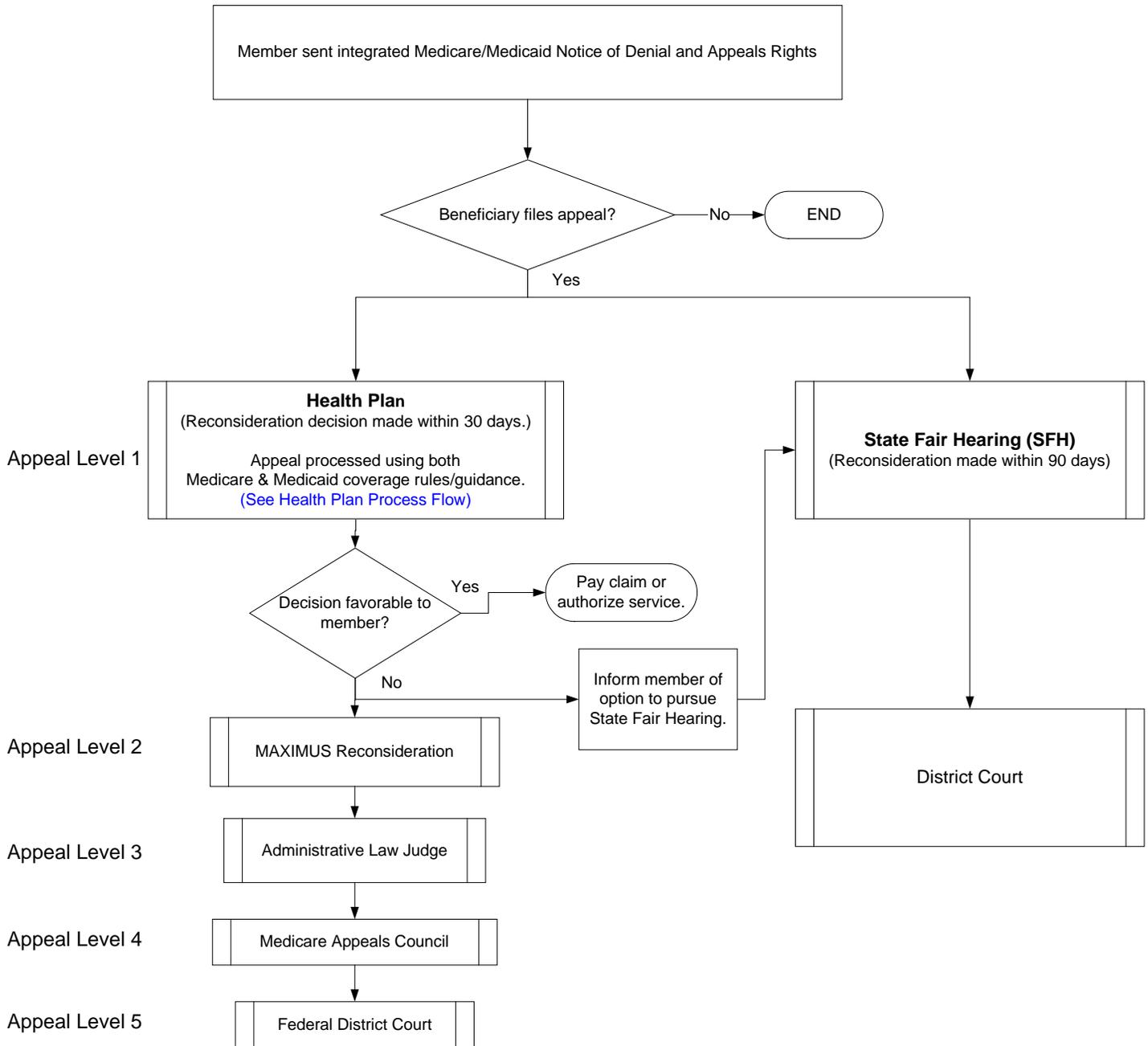
Market Incentives and Stimulation



**Appendix 2: Integrated Appeals and Grievances**

**SNP Integrated Appeal Process**

This process is used for services that could be covered under Medicare and Medicaid coverage rules/guidance.



**Note:**

- \* Medicare-only covered services follow the current Medicare Appeal Process.
- \* Medicaid-only covered services follow the current Medicaid Appeal Process.

SNP Integrated Health Plan Appeals Process - 12/04/2007

