



DRAFT March 2, 2012

CMS PROPOSAL OUTLINE

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 Part D 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 and improving the experience of dual eligibles by reducing confusion. 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 when they are 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 payment pilots 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).

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/dhs16_163573).

C. 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/MCTOC and dual integration efforts into a new, aligned purchasing model for seniors and to explore additional models 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 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.

D. 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.

E. 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 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, CMS and demonstration entities enter into three-way contracts 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.

F. Target Population

Target Population (monthly average enrollment based on FY 2011)	All full benefit dual eligibles 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
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	106,178 (1/12 enrollment)
Total Number of Beneficiaries Eligible for Demonstration	93,165
Geographic Service Area	Seniors: Statewide Disabilities: Statewide contingent on further negotiations with CMS
Summary of Covered Benefits	Seniors and Disabilities: Medicare A, B, D and Medicaid State Plan including mental health Seniors: 1915(c) Elderly Waiver Disabilities: PCA, CADI, TBI and I/DD 1915(c) waivers under fee for service
Financing Model Is this proposal using a financial alignment model from the July 8 SMD? Payment Mechanism	Yes Seniors: Capitation Disabilities: Capitation with potential for FFS shared accountability model for HCBS
Summary of Stakeholder Engagement/Input See Section T.	Seniors Stakeholders Group: 3 meetings Disability Managed Care Stakeholders Group: 31 meetings Special Needs Plan Stakeholders Group: 6 meetings Other Groups: 15 presentations Website: http://www.dhs.state.mn.us/dhs16_163573 Publication of Draft Proposal: March 19, 2012
Proposed Implementation Date(s)	December 2012 for seniors, 2013 for people with disabilities

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.

About 45,394 dually eligible seniors are enrolled in two statewide managed long term care programs offered by eight Medicaid health plans, all of which are also 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.

In January 2012, there were also about 54,392 people with disabilities between the ages of 18 and 65 who are full benefit dually eligible. Less than 5% reside in nursing homes, about 34% receive home and community based services through three waiver service programs and 62% reside in the community without waiver services but may qualify for personal care assistance services. 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 all Medicaid mental health services and excludes most long term care services which remain 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 currently serves about 6,161 dually eligible members but 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 de-coupled from Medicare because only three of the five SNBC plans have D-SNPs. Only 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.

DHS intends to continue discussions with CMS about the potential of including dually eligible people 18-64 who have chosen to enroll in SNBC in a second phase of the demonstration with a special focus on integration of physical and mental health for community members with primary diagnoses of mental illness.

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

Minnesota has been working on integrated Medicare and Medicaid services for dual eligibles since 1991. In 1995 Minnesota became the first state to obtain CMS approval for a Medicare demonstration that allowed integrated Medicare and Medicaid 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 Plans (MA D-SNPs) 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 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.

This has been particularly problematic for D-SNPs serving people with disabilities. A total of five SNPs serving people with disabilities in Minnesota have dropped out of Medicare Advantage citing financial viability reasons since 2009. 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. Other SNPs serving people with disabilities 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 D-SNPs are now required to have contracts with states for Medicaid services, 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 requirements aligned with Medicare and new requirements just announced for 2014 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 requiring waivers of the 3 day hospital stay for access to SNF care and most Minnesota D-SNPs cover 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 nor produce standardized systemically measurable outcomes. For various reasons including reluctance to take risk, relatively few plans and providers have entered into these arrangements and 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 take successful dual demonstration models and make them permanent, giving Minnesota a chance to apply its expertise in this area to shape a new national policy. A move back to demonstration status seems 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

Under the new demonstration authority, enrollment for the demonstration and Medicare services would continue to be voluntary. Current MSHO D-SNPs participating in MSHO and current MSHO enrollees would transition as seamlessly as possible from Medicare Advantage SNP status and enrollment under the same plan sponsors to Medicare/Medicaid Integrated Care Organizations (MMICOs) on January 1, 2013, ensuring that that current care for frail members (average age 80) is not disrupted while further purchasing reforms are being developed and implemented. Continued access to integrated Medicare, Medicaid and Part D financing will be provided through the three-way integrated financing agreements with CMS for MMICOs.

DHS would also request 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. A

modest cost savings for this group is expected since their Medicare services have remained largely fee-for-service. 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.

Enrollment of people with disabilities into the Medicare/Medicaid demonstration would need to be determined contingent on viable 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 choosing to enroll.

I. Geographic Service Area

The demonstration would be statewide for seniors. SNBC managed care program for people with disabilities operates in 78 of 87 counties. 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 to 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 include all providers for Medicare and Medicaid services. 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 “grandfather” in existing D-SNP and MCO networks as part of the MMICO transition. 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 must also be reported to the State and CMS.

K. Proposed Purchasing and Care Delivery Models (See Attachment A).

Under the umbrella of integrated Medicare and Medicaid financing created through the demonstration for the MMICOs, DHS will incorporate HCDS purchasing strategies similar to those being implemented for other populations to stimulate new “integrated care system partnerships” 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.

MMICO contracts 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, Models 3 and 4 below would be implemented no later than January 2014.

a. Service Delivery Models

In order to accommodate the wide variety of current revenue arrangements between MMICOs, providers and counties, and not to disrupt long standing care coordination arrangements for frail members 72% of whom receive some long term care services, DHS will allow several service delivery and risk/gain sharing models with increasing levels of payment reform and risk/gain sharing arrangements under the new demonstration. All models will have a primary focus on providing a seamless and simplified experience for the enrollee.

b. Care Coordination

Requirements for individualized care coordination across all services, interdisciplinary teams, care plan audits and care system audits for seniors would remain. Care coordination functions may reside

with the HCH, county/community organization, MMICO, or care system depending on the partnerships between MMICOs and providers within the models outlined below. The State would 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 home and community based and other long term care services.

For people with disabilities, current navigation assistance requirements under SNBC would be enhanced to encourage further integration of physical and mental health under Model 4 below. Additional care coordination requirements would be dependent on the financing arrangements negotiated with CMS.

The State is working with stakeholder groups to identify communication tools and strategies to promote closer ongoing communications between MMICOs, primary, acute, post-acute, community based, county and long term care providers. Recommendations for these tools are expected prior to implementation (see Model 1 below).

Model 1. Primary Care Health Care Homes “Virtual Care Systems”: All enrollees would be required to choose a primary care clinic, preferably a certified HCH where available. MMICOs would continue to be required to provide payments to HCH as currently required under MSHO/MSC+ and SNBC contracts, unless more aggressive 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 paid out of Medicare savings, and be considered part of the initial Medicare plan 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 similar to the fee for service MAPCP demonstration and provide an immediate though small savings to the State. Since not all clinics are certified as health care homes, MMICOs would also be required to develop provider contract requirements that encourage their participating clinics to become HCH and would facilitate member’s assignment into health care homes for primary care unless that would disrupt current care relationships.

In addition, building on current models being developed through the State’s AOA grant for Integrated Systems Development, the State would utilize standardized shared communication strategies and secure electronic communications tools to encourage “Virtual Care System” communications between MMICOs, HCH, counties, 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.

Model 2. Alternative Health Care Home/Care Systems: Some MSHO plans already have creative contracts with provider care systems (clinics or physician groups) that include prospective full or partial capitations or care coordination payments for all Medicare and Medicaid care coordination functions (including HCBS case management). These entities may or may not be HCH. Some provider care systems have chosen not to be HCH but through contract arrangements with current MSHO plans they perform duties similar to HCH for their enrolled members. These payments allow 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 Medicaid long term care coordination, so providers may wish to remain in these arrangements. 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. These arrangements are currently reported to DHS and could be “grandfathered” in under the new demonstration. However, the new MMICO contract would require development of a consistent set of outcome measures to be applied to all care system arrangements and reported to DHS annually. Such measures would include those tied to performance based payment withholds. Contracted involved primary care providers should also be required to participate as HCH in order to qualify for such arrangements,

though a transition period will be necessary before this can become a contract requirement given the voluntary nature of HCH certification.

Model 3. 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) between providers and MMICOs to provide integrated delivery of primary, acute and long term care services to MMICO members that include primary care payment reform and risk/gain sharing. Primary care providers under ICSPs would be required to be certified as HCH. DHS will use elements and experience from Model 2 and current HCDS to build its RFP requirements for aligned financing across partners, encouraging aligned participation of acute and primary care health systems and HCH/primary care providers with post-acute and long term care providers and others including counties and mental health providers under contracts with MMICOs. Current care systems (Model 2) would have the option of remaining in their current arrangements.

As under the current managed care “care system” arrangements, this would be a primary care system model, where enrollees would choose or be assigned (not attributed) to primary care arrangements within the ICSP care systems, facilitating tracking of costs and outcomes necessary to assure alignment and accountability throughout the continuum of care and with appropriate marketing protections to preserve enrollee choice of primary care provider.

The RFP for these partnerships will require that interested ICSP providers and MMICOs 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 arrangements that partnerships can choose, including flexibility for graduated levels of risk/gain sharing across all services and standardized risk adjusted outcome measures, along with 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.) 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 relationships. The State (for work load management purposes) would have the right to limit the number of new ICSP participants.

Model 4. Potential SNBC Mental and Physical Health Integration Partnership: 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 issue RFPs for a Health Home or HCH partnership between SNBC MMICOs, primary care, post- acute care providers, mental health providers and/or counties for SNBC enrollees with primary diagnoses of mental illness. The RFP would encourage integration of physical health and mental health services under MMICOs serving people with disabilities ages 18 to 64 with primary diagnose of mental illness. This could be modeled after the existing PIN mental health initiative which is a partnership between a county and an SNBC plan.

Further negotiation with CMS would be needed around CMS requirement to include long term care services under capitation for this group. Current DHS policy does not provide for capitation of HCBS waiver services and long term services and supports. However, CMS has said they may consider allowing “virtual integration” models with “shared accountability” under fee for service arrangements in lieu of full capitation of long term care.

L. Benefit Design

Minnesota provides a very robust set of State Plan and HCBS waiver services under its current Medicaid benefit. The State intends to have the HCH benefit offered as a new supplemental Medicare benefit under a Medicare savings scenario. 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.

In addition, the State would continue existing features of these programs in place for seniors including integrated care coordination across Medicare and Medicaid primary, acute and long term care, assignment of individual care coordinators, fully integrated member materials, initial health risk assessments, assessment and management of HCBS including provision of access to 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.

For people with disabilities, current Medical Assistance benefits would remain the same as those capitated under SNBC with the same proposed change in HCH. The State is also exploring the incorporation of the Health Home option for segments of this population.

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 response letter to the July 8, 2011 CMS State Medicaid Director's letter on October 1, 2011.

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 combine the Medicare and Medicaid performance based withholds with any new measures to be determined under the three-way contract.

While CMS has set some broad parameters for 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 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 whether changes would 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 plans indicates that new enrollees have a host of unmet health needs in the first year of enrollment and that Medicare risk adjustment does not capture those 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 3 and 4 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 Disability Payment System for SNBC which is expected to remain in place. The State's actuary will provide additional analysis for the payments under the dual demonstration.

O. Measurement and Evaluation

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 most important for dually eligible populations. 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 home and community based and other long term care services. The State is in the process of engaging a contractor to assist in identifying which measures are most appropriate for dually eligible demonstration participants.

CMS has already announced that they have chosen RTI working in conjunction with a number of subcontractors, as their contractor for the formal evaluation. Other federal efforts through the National Quality Forum are underway to identify more appropriate measures for dually eligible beneficiaries.

The State will build on the RARE (Reducing Avoidable Hospital Readmissions Effectively) initiative to continue efforts to avoid hospital readmissions. The Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association (MHA), and Stratis Health, the CMS Quality Improvement Organization (QIO) are leading the statewide RARE campaign with managed care organizations, 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.rareadmissions.org/>

In addition, the State will continue to partner 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. For example, the State's managed care contracts require that the plans cooperate with MNCM to retain and apply race and ethnicity data supplied by DHS when needed for cross system measurements to measure disparities and related issues.

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 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 choosing an external contractor to integrate Medicare and Medicaid fee-for-service and encounter data and assist with analytic tools for risk adjustment and standardized measurement for on-going program metrics. The contractor will 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. Beneficiary protections would be enhanced by this demonstration.

Contracts currently include continuity of care and transition requirements for plans to provide the same services with the same providers for medical and as a 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 protection 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. Specially trained Managed Care Ombudsman staff are available to assist enrollees with resolving their concerns or submitting a grievance or appeal. 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 also collects, tracks and analyzes grievance and appeal information as well as information about all denials, terminations and reductions in service (DTRs).

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 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. MSC+ currently operates a waiver under authority of §1915 parts (b) and (c) of the Social Security Act. MSHO operates under authority of §1915 (a) coupled with §1915(c) for home and community based services. SNBC operates under §1915(a). 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.

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 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 operational requirements to reduce administrative burdens and costs.

S. 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 entities) participating in the State's managed care programs and the Minnesota Department of Commerce, which oversees financial compliance.

Within DHS, primary responsibility for the demonstration lies within the Health Care Administration (HCA). Since the State currently operates managed care programs for seniors and people with disabilities which are expected to transition to demonstration status, current resources will be utilized to implement and oversee the dual demonstration. These include the following:

Within HCA, under the Purchasing and Service Delivery Division (PSD) 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, and the Managed Care Ombudsman Program, 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 help sort out 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 Mental and Chemical 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. These 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.

T. Summary of Stakeholder Involvement

The State has conducted extensive efforts to involve affected stakeholders in the demonstration development process. Two overarching external stakeholder groups were established 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. Six highly attended meetings have been held thus far for people with disabilities with an additional five subgroups and 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 twelve presentations to community and provider groups about the demonstration and continues to solicit broad input from the community.

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 and 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.

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. Enrollees will 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.

U. Implementation and Timelines (See Attachment B).

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 plans to amend its contracts for current managed care organizations serving seniors in conjunction with the three-way agreement process required under the demonstration and to transition current members seamlessly to the demonstration effective January 2013. This will 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. 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 March 2013, with a planned implementation date of September 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.

Please submit comments to:

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