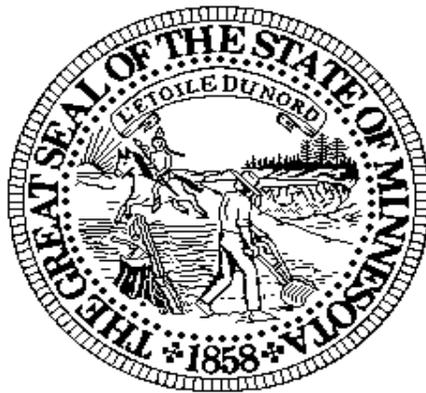


Redesigning Integrated Medicare and Medicaid Financing and Service Delivery for People with Dual Eligibility in Minnesota

*Design Proposal to the Center for Medicare and Medicaid Innovation
Contract No. HHS-500-2011-00035c*



April 26, 2012

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CMS DESIGN PROPOSAL

Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

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I. Health Reform in Minnesota and Executive Summary

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 Centers for Medicare and Medicaid (CMS) Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), implementation of Health Care Delivery System Demonstration (HCDS) and Medicaid total cost of care (TCOC) payment 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 for people who are dually eligible for both programs. (See Minnesota's Medical Assistance Reform website and report: www.dhs.state.mn.us/MAREform.)

People with dual eligibility for Medicare and Medicaid have the highest rates of chronic health conditions yet face a complex service delivery system fragmented between two large health care financing entities with conflicting and unaligned financing policies. While there are only about 10 million people with dual eligibility in the nation, services for this group account for a disproportionate share of spending for both Medicare and Medicaid. Alignment of Medicare and Medicaid policy and financing incentives along with further integration of service delivery have been widely recognized as critical to improving both the efficiency and quality of care for people with dual eligibility.

Minnesota is a national leader in developing innovative aligned Medicaid payment and care delivery models for primary and acute care such as the above projects currently being implemented. Minnesota has also been the 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. The State currently contracts with eight Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) which provide integrated Medicare and Medicaid managed long term care services to most dually eligible seniors in the State. In addition the State is expanding enrollment of dually eligible people with disabilities ages 18-64 under its managed care program for people with disabilities which is provided through five Medicaid plans, three of which also offer integrated D-SNPs.

New demonstration initiatives offered by the CMS for integration of Medicare and Medicaid provide Minnesota an opportunity to improve these managed care programs and assure their stability into the future. The new demonstration allows states to have a stronger role in contracting for Medicare services and allows further integration of policies designed to provide a seamless experience for enrollees while retaining payment and coverage flexibilities allowed under Medicare Advantage. This demonstration provides Minnesota with a unique opportunity to influence Medicare primary, acute and post-acute care for people with dual eligibility.

Executive Summary: Capitated Alignment Demonstration

Under the capitated aligned Medicare and Medicaid financing demonstration offered by CMS, Minnesota proposes to combine its experience with innovative HCH, HCDS/TCOC and dual integration efforts into new, improved aligned purchasing models for seniors and people with disabilities who are dually eligible for Medicare and Medicaid services. The State will strengthen aligned incentives for accountability for performance improvement and total cost of care across both payers by developing additional provider based payment reform and care delivery innovations, and will continue to focus on person-centered individualized care coordination and integrated operations to achieve a seamless beneficiary experience. These reforms are designed to reposition the current programs to improve performance, viability and stability for both Medicare and Medicaid into the future. (See Minnesota's Demonstration to Integrate Care for Dual Eligibles website: <http://www.dhs.state.mn.us/dualdemo>).



The new demonstration would include dually eligible seniors enrolled in eight local non-profit health plans through two statewide managed long term care programs: Minnesota Senior Health Options (MSHO) and Minnesota SeniorCare Plus (MSC+) and would be implemented December 31, 2012. In a second demonstration phase to begin July 2013, the State would include dually eligible people with disabilities now enrolled in Special Needs BasicCare (SNBC) which is currently offered by five of the plans. While SNBC does not include most long term care services, it does include all behavioral and mental health services. Inclusion of SNBC members would be contingent on reaching agreement with CMS for a viable financial model including shared accountability for non-capitated services including home and community based waivers.

Under the demonstration, current health plans and county based purchasing entities now operating under separate Medicare and Medicaid contracts would become Medicare Medicaid Integrated Care Organizations (MMICOs) through the three-party contracts offered by CMS. The State would implement purchasing, delivery and payment reforms to re-design the existing programs through increased participation of provider-based integrated care system partnerships with a focus on increased accountability and improved outcomes. The State proposes three basic models of service delivery using its current HCH initiative as a base. *Model 1* would facilitate improved communications and relationships between HCHs, MMICOs, counties, tribes and providers under a “Virtual Care System” approach. Under *Model 2*, the State would develop service delivery criteria, risk and gain models, and performance metrics and would solicit proposals for Integrated Care System Partnerships (ICSPs) between provider care systems and MMICOs. Similar to the current HCDS initiative and building on current care systems already operating under MSHO, the State would facilitate these contracting relationships through a Request for Proposals (RFP) process. Under *Model 3*, the State would build on current integrated mental and physical health services experience to stimulate additional ICSPs that would focus on integration of physical, mental and chemical health for people with disabilities. (See Appendix 1 for a chart outlining these models.)

Current MSHO enrollees would transition seamlessly into the new demonstration without disruption in current services. MSC+ enrollees not already enrolled in a Medicare D-SNP would also be offered the chance to enroll in the demonstration through an opt out process. SNBC enrollees would be offered the opportunity to enroll in expanded integrated Medicare Medicaid programs in a second phase starting in July 2013. The State requests additional payment and operational waivers or permissions in order to implement the new programs and will also incorporate already extensive current contract and operational requirements for integrated enrollment, member materials, care coordination and consumer protection. (See Appendix 3 for details of these requests.)

The State has involved stakeholders in the discussion and development process of this proposal through Stakeholder groups including consumers, advocates, providers, health plans, tribes and counties. Approximately 56 meetings and/or presentations have been made about the demonstration. The State has established and maintains a large listserv of interested parties, a special website and a dedicated email address to facilitate communications with stakeholders around this demonstration. See Appendix 4 for further documentation of these stakeholder meetings. The State published a draft proposal on March 19 for a 30 day comment period. Comments were due April 19, 2012. Twenty-six comments or letters of support were received from 22 different organizations and individuals. Only one commenter expressed opposition to proceeding with the demonstration. Comments and letters of support are included in Appendix 6 of this proposal. The State has incorporated many comments into this proposal and will continue to work with the commenters to clarify questions and address their many constructive suggestions. A stakeholders meeting to discuss public comments and questions about the final proposal is scheduled for April 27, 2012. All commenters have been invited to participate.

A. Table 1: Target Population and Benefits Description

Target Population (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 are enrolled in or choose to enroll in MSHO/MSC+ or 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 (January 2012)	106,178
Total Number of Beneficiaries Eligible for Demonstration (January 2012)	93,165
Geographic Service Area	Seniors: Statewide Disabilities: Statewide contingent on further negotiations with CMS
Summary of Covered Benefits	Seniors and Disabilities: Medicare Parts A, B, D and Medicaid State Plan services including mental health and CD treatment services Seniors: LTSS (Elderly Waiver (1915 (c) and all Medicaid PCA and 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
Financing Model 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
Summary of Stakeholder Engagement/Input See Section XX and Appendix 4.	Approximately 56 meetings held including: Seniors Stakeholders Group: three meetings Disability Managed Care Stakeholders Group: five meetings with 18 additional meetings SNP Stakeholders Group: seven meetings Tribes: three special meetings Other Groups: 20 meetings and presentations Website: http://www.dhs.state.mn.us/dualdemo Publication of Draft Proposal: March 19, 2012 23 comments received (as of April 19, 2012)
Proposed Implementation Date(s)	December 2012 for seniors, July 2013 for people with disabilities
*LTSS-Long Term Services and Supports, 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)	

II. Current Managed Care Programs for Dually Eligible Seniors and People with Disabilities

A. Seniors (Age 65 and older):

Most dually eligible seniors are currently enrolled in two statewide (all 87 counties) managed long term care programs offered by eight local non-profit Medicaid health plans, all of which also currently sponsor fully aligned D-SNPs for seniors. About 79% of dually eligible seniors enrolled in managed care in Minnesota are already enrolled in aligned Medicare and Medicaid programs. Enrollment in Minnesota Senior Care Plus (MSC+) is mandatory. However MSC+ serves only about 10,272 dually eligible seniors (as of the April 1, 2012 enrollment)

because seniors can choose to enroll in an integrated program, Minnesota Senior Health Options (MSHO) as an alternative. MSHO is provided through contracts with eight Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) sponsored by the same eight Medicaid health plans. MSHO serves about 36,128 dually eligible seniors (as of the April 1, 2012 enrollment). Members who enroll in MSHO receive all Medicare benefits through the MSHO D-SNP, including Part D pharmacy benefits. Most MSC+ members are enrolled in Original Medicare and must choose a separate Part D plan for pharmacy benefits. MSHO and MSC+ are managed long term care programs that enroll members in all settings and cover the same Medicaid benefits including State Plan services: behavioral, mental and chemical health services, long term services and supports (LTSS) and nursing home care.

1. People with Disabilities (Ages 18-64):

Historically, most dually eligible people with disabilities have received their State Plan services through fee-for-service (FFS). However since 2008 the State has offered a voluntary managed care option for people with disabilities including those with dual eligibility called Special Needs Basic Care (SNBC), which was designed with assistance from a large ongoing stakeholder group. SNBC is provided through five Medicaid managed care plans and includes most State Plan services and all Medicaid mental and chemical health services and some long term care services (home health and 100 days of nursing home services). SNBC coordinates with LTSS including personal care, private duty nursing and four disability LTSS waivers. These waivers remain available through a managed county and state system based on state determined risk adjusted/capped funding allocations to counties which include any SNBC members requiring services. SNBC operates in 78 of 87 Minnesota counties and is expected to operate in all counties by the end of 2012.

About 47,736 full benefit dually eligible people are eligible for managed care enrollment in SNBC. Enrollment in SNBC is being expanded, and as of April 1, 2012 SNBC had about 20,462 members of which about 12,253 (60%) 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 Medicare/Medicaid program in 2008 but enrollment of people with dual eligibility was recently de-coupled from Medicare because only three of the five SNBC plans now have D-SNPs. (Since 2008, four SNBC plans dropped their D-SNPs and/or left the program entirely.) There are about 1,102 dually eligible members who remain enrolled in the three integrated SNBC D-SNPs. Most SNBC members now receive Part D benefits through a separate Part D plan. Overall, people with dual eligibility are slightly more likely to enroll in SNBC than non-dually eligible people. People with disabilities who turn 65 while enrolled in SNBC are allowed to remain in that program as an alternative to MSC+.

III. Population and Utilization Description (See Tables 2 and 3)

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.

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 through 64 on Medicaid are dually eligible, and about 300 become dually eligible per month when their waiting period for Medicare benefits ends.

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 of 74. Forty-seven percent (47%) of the population had a diagnosis of Alzheimer's or dementia; 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 dually eligible people with disabilities was 53,363. At that time, SNBC was a much smaller program, only enrolling about 5.7% of all dually eligible people 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, 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 also use PCA services.

A. Table 2: Target Population for Phase 1:

Dually 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 ¹	%	N	%	N	%	N	%	N	%
Target Population	46,615	100.00%	13,542	29.05%	18,962	40.68%	1,184	2.54%	12,927	27.73%
Age										
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%
Current Plan										
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%
Diagnoses										
Dementia/Alzheimer's ²	21,908	47.00%	9,990	73.77%	9,640	50.84%	305	25.72%	1,974	15.27%
SMI ³	7,649	16.41%	3,776	27.88%	2,713	14.31%	376	31.77%	784	6.07%
SPMI ⁴	600	1.29%	93	0.68%	318	1.68%	57	4.77%	133	1.03%
Services										
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 ⁵	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%

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

² Dementia / Alzheimer's: CMS CCW definition "Alzheimer's Disease and Related Disorders of Senile Dementia (http://www.ccwdata.org/cs/groups/public/documents/document/ccw_conditioncategories.pdf)

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

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

⁵ Includes Assisted Living, Residential Care, Adult Foster Care (corporate)

B. Table 3: Target Population for Phase 2:

Dually 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, CADI, I/DD, BI)		Residing in community with no waiver services		SNBC		Fee for Service (FFS)	
	N ⁶	%	N	%	N	%	N	%	N	%	N	%
Target Population	53,363	100.00%	2,523	4.73%	17,989	33.71%	32,851	61.56%	3,055	5.73%	50,308	94.27%
Age												
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+ ⁷	49	0.09%	6	0.23%	22	0.12%	21	0.06%	49	1.61%	-	0.00%
Current Program												
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%				
SMI Only ⁸	8,621	16.15%	99	3.92%	1,790	9.95%	6,732	20.49%	592	19.37%	8,029	15.96%
Disability Types (may have more than one)												
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 ⁹	21,641	40.55%	913	36.19%	7,389	41.08%	13,338	40.60%	1,479	48.40%	20,162	40.08%
SPMI ¹⁰	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%
Services												
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 ¹¹	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%

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

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

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

⁹ Definition of Serious Mental Illness (SMI): receiving 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 two 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 one inpatient claim or two outpatient claims containing the diagnosis in the past two years.

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

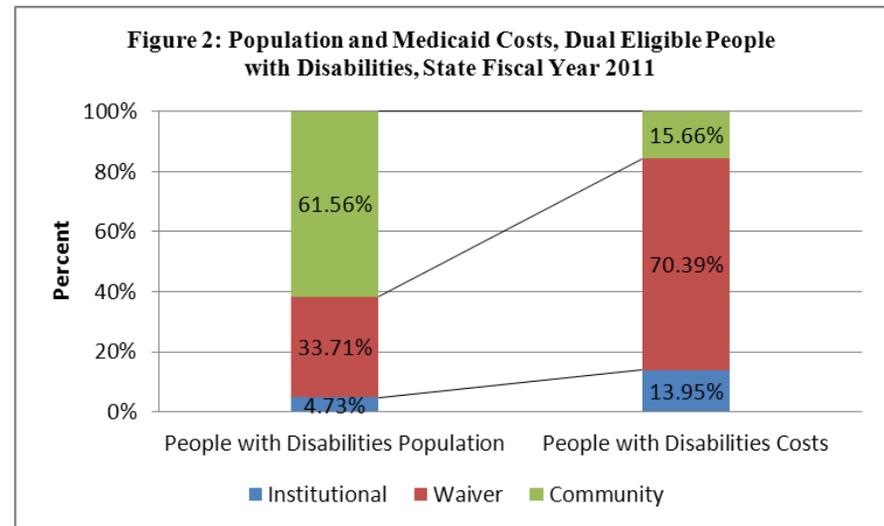
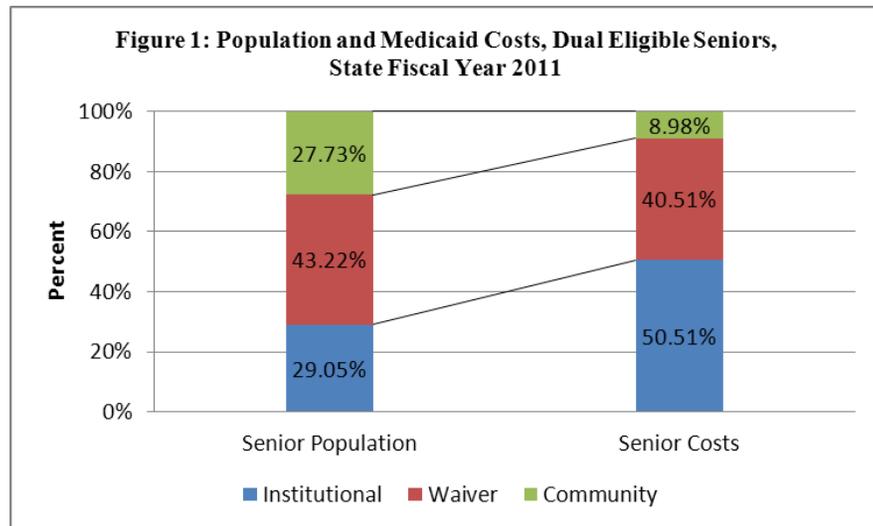
¹¹ Includes Corporate Adult Foster Care and Customized Living

IV. Total Spending For Dually Eligible People In Minnesota

Table 4: Total Medicaid Costs¹² 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
All Eligible Duals	\$838,206,344.00	\$4,347.88	\$1,444,601,574.00	\$3,156.80	\$321,006,614.00	\$584.35	\$2,603,814,533.00	\$2,170.32
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.



¹² Medicaid costs include all capitation and State Plan or FFS costs

V. 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 Medicare 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 people with dual eligibility. However, the future of D-SNPs as a continued platform for Medicare/Medicaid integration remains unclear. Congress must reauthorize CMS authority for all SNPs for 2013 in order for D-SNPs to continue. The financial bid processes under Medicare Advantage are not designed with people who are dually eligible in mind and can result in premiums that they 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.

Medicare Advantage rate reductions and lower than average benchmarks are 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 related to Medicare payment. 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 people with dual eligibility. Despite the assistance of CMS staff, frequent SNP policy changes have made it a constant challenge to keep Medicaid policies aligned with Medicare. 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 necessary for reducing cost shifting and for creating efficiencies in care delivery. For example, under Medicare Advantage, health plans are allowed to waive certain FFS 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 FFS-based payment methods for clinics and post-acute providers such as SNFs. When coupled with immediate access to Medicaid home and community based 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 community 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 which have largely been focused in metropolitan areas.

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 demonstration provides the first wide scale opportunity to give states a larger role in influencing Medicare policy for people with dual eligibility. 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, under Sections 1115a (c) and 1115a (b) of the Social Security Act there is federal authority to make successful demonstration models permanent after rigorous evaluation, 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 people with dual eligibility and for improving integrated payment and service delivery models in accordance with other Medicaid reforms to ensure long term viability.

VI. 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) through the CMS/State joint certification and application process provided under the demonstration parameters. Enrollment for current MSHO members would continue seamlessly under the same plan sponsors, ensuring that current care for frail members is not disrupted. 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. Medicare enrollment would remain voluntary and people would continue to have the right to enroll or disenroll in any month thereafter.

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 in compliance with 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 DHS Continuing Care Administration including the State Health Insurance Assistance Program (SHIP). 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 designated State SHIP (the Senior LinkAge Line) as well as the Disability Linkage Line, 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. (A large majority of these members regain eligibility within that 90-day period.) 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. The State requests that this current Medicare D-SNP enrollment policy of temporary retention of members for up to six months remain in place for people with dual eligibility under the demonstration in order to accommodate the numerous cases of temporary disruptions in Medicaid eligibility in the manner described here. It will be important to retain these features under the new demonstration.

Transition from the current D-SNP programs to the new demonstration should be seamless for current D-SNP members, based on previous experience when the State moved from demonstration status to D-SNP status in 2005 and 2006. The State proposes that each current D-SNP member would get a joint notice from the State and the demonstration plan (CMS could also be included in the joint notice) informing them that the MSHO and SNBC programs are moving to the demonstration, that enrollment in their current plan will continue without disruption and that no action on their part is required to maintain enrollment in their current plan. 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). Members would retain their right to dis-enroll or re-enroll at any time effective in accordance with CMS policy on the first of the next month. 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 including newly eligible seniors on an ongoing basis. 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 and transition of people with disabilities from SNBC into the Medicare/Medicaid demonstration would follow a similar process but would be implemented in a second phase in mid-2013.

A procurement for people with disabilities is needed to meet State managed care procurement criteria for 2013. We propose to coordinate that procurement with the joint State/CMS procurement and certification process for participation in the demonstration under Medicare for implementation in the second phase of the demonstration.

SNBC enrollees who have already chosen enrollment in integrated D-SNP arrangements (a smaller group of about 1,500) would also be seamlessly transitioned from D-SNP to demonstration enrollment with notices and a similar process as described above for seniors. Medicare enrollment would remain voluntary and people would continue to have the right to opt out prior to enrollment and in any month thereafter. New enrollees or enrollees currently enrolled in the SNBC plans who have not had an integrated option available or who have not yet chosen to enroll in the Medicare option would be given the option of voluntarily enrolling for Medicare. However, proceeding with enrollment for this group will be determined contingent on agreement with CMS for viable Medicare financial and shared accountability models reflecting state long term care policy for people with disabilities. MMICOs would also be responsible for assuring continuity of current Part D pharmacy benefits for all enrollees with disabilities choosing to enroll. The State is examining current Part D transition requirements and will work with demonstration plans and stakeholder groups on any further protections determined necessary.

VII. 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, EOC documents, 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 that 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 upon completion 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 these notices are upsetting and

confusing to the enrollee. The State proposes that an integrated form be developed as a model document for use by all demonstration plans.

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 and would not meet the needs of our enrollees.

VIII. Geographic Service Area

Seniors: The State will build on the current MSHO and MSC+ programs which operate statewide.

People with Disabilities: The State intends to build on the current SNBC program for enrollment of people with disabilities under the demonstration. The current SNBC managed care program for people with disabilities operates in 78 of 87 counties. However, only about 500 people with dual eligibility reside in counties without a current SNBC plan option. The State has issued an RFP for SNBC coverage in the nine uncovered counties and expects that all counties will be covered by the second phase of the demonstration for people with disabilities. The demonstration would be statewide for people with disabilities pending additional financing discussions with CMS around the shared accountability model and Medicare payment policies for people with disabilities.

IX. 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 people with dual eligibility where there are small numbers of members and where the State is encouraging more selective contracting with integrated care systems demonstrating expertise in serving dually eligible populations. Additional network requirements under current 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.

Plans serving seniors may utilize county developed networks for community LTSS providers or may develop their own networks but must have oversight plans in place for those providers. (See § 9.3.21 of the Seniors contract at link below.) In addition to requirements for provision of information on available EW providers to enrollees, the State requires that plans submit an updated list of all Elderly Waiver providers to the State each year. (See § 3.5.2(E)(3) of the Seniors contract at link below.)

The State requests that CMS deem existing D-SNP and MCO networks as acceptable under the demonstration 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 § 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 and http://www.dhs.state.mn.us/dhs16_166539.pdf

X. 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 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 be sponsored by HCDS, HCH/clinics and care systems, mental health providers, post-acute and long term care providers, tribes and/or counties. These partnerships would be designed to integrate primary care with long term care and/or mental and chemical health and would 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. Current MSHO requirements for waiver of three-day hospital stays and payment of in-lieu of days would continue.

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. *Model 1* below represents typical current service delivery arrangements but would improve those current systems by increasing use of HCH and improving communications between providers around transitions and care planning. The State’s goal is to increase the number of people with dual eligibility 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. Demonstration enrollees would continue to be served under their current arrangements until new models are in place and would continue to choose their primary care provider under all arrangements as provided in current contracts.

In addition, MMICO contracts and provider subcontracts will include standardized performance outcome measures to be applied to the integrated care systems appropriate to the populations served. 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, the additional *Model 2* solicitations would be implemented in July 2013 for seniors. *Model 1* could also be available immediately for seniors, as well as people with disabilities under the demonstration. Variations in *Model 2* could be addressed to accommodate differences in the scope of benefits and care coordination for this people with disabilities. 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 may 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 (where each enrollee has a single care coordinator) across all Medicare and Medicaid 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. These requirements are outlined in the current Medicaid contracts and have already been incorporated into 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 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 ICSPs and/or other 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 people with dual eligibility, 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 with modifications as needed. (See the Model MSHO/MSO+ Contract in §§ 6.1.4-6, 7.9 and 9.3.9.) http://www.dhs.state.mn.us/dhs16_166538.pdf . For the Seniors collaborative care plan audit protocols see: http://www.dhs.state.mn.us/dhs16_167851

Collaborative efforts on improving care transitions will also continue to be required for MMICOs and the ICSPs. The current Minnesota D-SNP Improving Care Transitions Collaborative includes all plans serving people with dual eligibility 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 also contained in the current 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 the DHS Administration's 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. See below for training documents used by the Transitions Collaborative. http://www.dhs.state.mn.us/dhs16_147554.pdf

Safe, effective and efficient care transitions will be a continued focus under requirements for the new ICSP purchasing strategies. Transition protocols under the demonstration will also be reviewed and modified as needed to consider implementation of proposed changes in the state's nursing home level of care criteria. Demonstration plans, care coordinators and ICSP providers will need to oversee transitions for members who may no longer qualify for elderly waiver or nursing home services but may qualify for other State Plan services or substitute benefits provided by the State.

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 2* and *3* 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 § 6.1.5-6), and § 9.3.9 at http://www.dhs.state.mn.us/dhs16_166539.pdf

Additional care coordination enhancements in Phase 2 for people with disabilities that would encourage further integration of physical and mental health under *Model 3* below would be based on experience, needs of the target population and requirements of the Preferred Integrated Network, a partnership between Medica (a managed care organization participating in SNBC) and Dakota County.

B. Service Delivery Models

1. 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/MSO+ 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 under 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 encourage 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/chemical health, acute, post-acute and LTSS 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. The State recognizes that the dually eligible population makes up a small proportion of patients for most primary care provider systems, yet there is a high need for improved communications tools around their transitions of care as they move between clinics, hospitals, nursing homes, group homes, mental/chemical health, home care and other long term care services. Therefore communications strategies should build on existing HCH requirements for appropriate sharing of care plan information, be compatible with current clinic health information technology and software systems, assist LTSS providers and other small providers with accessible secure communications solutions, and help to reduce duplication for consumers. Recommendations for these tools will be available prior to implementation of the demonstration.

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

Under this model, the State will issue 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. ICSPs would include primary, acute and long term care providers working together to integrate care delivery. Long term care providers, counties, or tribes working in

collaborative partnerships with or employing primary care providers would be eligible to be ICSP sponsors as well as HCDS and other primary and acute care providers working in collaborative partnerships with long term care providers. Primary care providers involved in ICSPs would be required to seek certification 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. MICCO and ISCP contract requirements/criteria for these new partnerships would include: use 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.

Under the ICSP model, the State will also work to incorporate and promote implementation of key elements of the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Home Residents. Elements could include use of Nurse Practitioner care models in nursing homes, waivers of three-day hospital stays, payment of in-lieu of days, partnerships with long term care providers including risk/gain sharing based on avoidable hospitalization rates, and protocols for support and training of long term care staff. (Also see Section XXIII.D below.)

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.

3. 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 because the HCH statute allows such alternative payment arrangements for integrated programs serving people with dual eligibility, 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 certification prior to such a contract requirement.

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. (See Section XXIV below for details on timing.)

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

Pending negotiations with CMS for transitioning SNBC plans to MMICOs under the 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 diagnoses of mental illness including those with 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 diagnoses of mental illness including co-occurring substance abuse, I/DD, brain injury, and other cognitive impairments. This could be modeled after the existing PIN mental health initiative which is a partnership between a county and an SNBC plan serving people with serious and persistent mental illness. Such models could also be adapted for other disability groups requiring high levels of mental health services. 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.

C. Evidence-Based Practices

MMICOs/ICSPs will continue to be encouraged through the RFP process and contract requirements to utilize evidence-based practices and guidelines to achieve specified improvements in outcomes for enrollees. Current plans utilize evidence based guidelines for Diabetes, CHF, COPD, Asthma, Obesity and Preventive Services for Older Adults, however, the State will take a more active role in guiding this effort to ensure consistency and increased accountability for population based outcomes. 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. In addition, 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, § 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. As part of this evaluation review plans may conduct audits of clinics to assure compliance with the measures, producing comparative performance measures at the provider level.

Minnesota is 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 settings. Most plans use ICSI standards for many chronic diseases including ICSI guidelines for Preventive Services for Older Adults.

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 §§7.2 and 7.3 of the 2012 contract, which would be carried over into the demonstration contract.

Current SNPs/MCOs also work in collaboration on their performance improvement projects under arrangements with Stratis Health, a locally based CMS contracted Quality Improvement Organization (QIO) for technical advice and project coordination. See Appendix 5 for a summary of these current performance improvement projects.

In addition, current SNPs/MCOs are working with numerous local and statewide efforts to encourage and measure the use of evidence-based practices such as those sponsored by Stratis Health, and Minnesota Community Measurement (MNCM), a consortium of health plans (including seven of the eight MSHO plans), physicians and hospital providers that facilitates collection of outcome measures and publishes comparative Health Scores across the State. It is important to continue to coordinate with these state-wide initiatives to reach the critical mass needed to focus efforts, obtain buy-in and reduce confusion for providers.

XI. 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 proposes to include the current HCH benefit in base costs for Medicare or to fund it out of Medicare savings. 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 programs for people with disabilities age 18-64. See Article 6 in each contract for a list of current covered benefits.

A. 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 State Plan benefits as well as 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 FFS 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) program, 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.

B. 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 the MFP program 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.

The history of managed care enrollment for people with disabilities ages 18-64 in Minnesota is long and complex. People with disabilities were included in the State's first managed care pilots in the 1980s, but this population was removed due to the drop out of a major plan option. In the mid-1990s legislation was passed for a new and controversial Demonstration Program for People With Disabilities (DPPD) which included LTSS and would have required significant cost savings and mandatory enrollment in certain areas of the State, however ultimately no health plans bid on the proposal. In the meantime, disability advocates assisted the State in development of a voluntary program integrated with Medicare, Minnesota Disability Health Options (MnDHO). MnDHO also included LTSS waiver services and operated in the Twin Cities metro area of the State starting in 2001 as part of the State's initial CMS Medicare payment demonstration. MnDHO was highly supported by consumers and showed excellent enrollee satisfaction but closed in 2010 after nine years of operation after the health plan sponsor had to drop its D-SNP due to high premiums.

This difficult history makes it all the more impressive that enrollment in the SNBC program, originally implemented in 2008, is now being expanded with an opt-out and assigned enrollment process and that advocacy groups are supporting inclusion of SNBC under this demonstration. Statutory authority established for SNBC provided a strong role for consumers, disability advocacy groups, counties and providers in SNBC program policy, development and implementation. The statute requires ongoing oversight by a statewide Managed Care for People with Disabilities Stakeholders group. The Stakeholders have been meeting since 2006 and was instrumental in the design and implementation of the SNBC program, including the legislative decision to exclude LTSS from health plan capitations. Membership in this group is open, and the group meets quarterly to discuss all aspects of the program with the State. Stakeholders continue to oppose control and capitation of personal care and other LTSS services under a single health plan entity.

Therefore, further negotiation with CMS would be needed around the 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), and four 1915(c) waivers

for LTSS applicable to people with disabilities age 18-64. However, all members remain enrolled in the SNBC plan including nursing home and ICF/DD residents and all other services continue to be managed through the plan.

All LTSS waiver services remain available to SNBC through a managed county and state system based on state determined risk adjusted/capped funding allocations to counties which include any SNBC members requiring services. County care managers authorize all services under this system, assessors determine individual needs and service plans, and service authorizations are submitted to the State including those for PCA and PDN State Plan services. The State monitors and oversees county aggregate capped funding allocations and sets assessment and audit criteria for service authorizations. SNBC plans are already required to assist members with access and coordination with these services. In many cases the SNBC plan contracts with the same county waiver case manager to provide SNBC care coordination. 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 demonstration arrangements outside of the health plan in lieu of full capitation of LTSS under a single entity.

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 MFP initiative. The state also provides numerous consumer directed options.

There is little chance of cost shifting to institutional care for this population in Minnesota since it has an existing accountable system for both health care and LTSS and is responsible for managing both sets of services with incentives for better integration and coordination of these services. 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 at the health plan level. The State has experience with inclusion of capitated waiver services under health plans for this population and found it highly complex. 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. It is also not clear that health plans would be willing or able to take on those complications, which have proved to be quite different from service delivery for seniors. Instead, for this population, the State would 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 a major barrier to care improvement.

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. Primary care providers serving these populations cite the lack of incentives for involvement of assisted living and group home providers in reducing preventable hospitalizations. New partnerships with these providers under ICSP arrangements as proposed under Section X through risk and gain sharing based on cooperation with primary care protocols and appropriate measurement of reductions in preventable hospitalizations could be encouraged without the need for full capitation of all LTSS waiver or facility costs.

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. In addition, 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, 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.

XII. 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 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 allows Medicare savings to be shared with the State.

A performance based withhold of 1, 2 and 3% respectively for years one, two and three of the demonstration is also required. (Minnesota already requires a substantial 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-party contracting process. Minnesota currently has performance based withholds related to reporting of treating and pay to providers on encounter data, repeat deficiencies on the MDH Quality Assurance Examination for Minnesota Health Care Programs (Seniors and SNBC), Care Plan audits (Seniors), timely completion of initial health risk screenings or assessments for community enrollees (Seniors), compliance with service accessibility requirements for dental provider offices (SNBC), and maintenance of regional stakeholder groups (SNBC).

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. 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 SGR payments 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 that must be addressed 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-party contracts with the State and the MMICOs before the demonstration can go forward.

XIII. Payments and Rates

Further information on MMICO and provider payment arrangements to be implemented under *Models 2* and *3* in Section X above 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 these payments under the demonstration. Medicare rates need to reflect the higher acuity of the populations enrolled through appropriate risk adjustments. The State requests that CMS apply its proposed Medicare HCC risk model improvements to the demonstration for seniors, including the proposed change for dementia and the increase in number of conditions considered under the model, both of which Med PAC 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 people with dual eligibility. This mechanism is carefully designed to protect the State as well as the MCO. (See § 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. 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. This will be necessary to incent MMICOs to participate in Medicare and to facilitate enrollment into the Medicare portion of SNBC. 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 HCC 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 along with the increase in number of chronic conditions which were found to be important for C-SNPs as studied by the General Accounting Office. Some HCH providers serving people with disabilities report that their members have on average eight or more chronic conditions.

XIV. 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 people with dual eligibility, 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 people with dual eligibility 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 people with dual eligibility. However, it is important to attempt to align with these efforts to avoid burdens and conflicting expectations for plans and providers. Please see Appendix 3 for additional requests and suggestions for further alignment between Medicare and Medicaid on measurement, evaluation and reporting requirements.

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 already being developed. Other federal efforts through the National Quality Forum such as the Measure Applications Partnership (MAP) are underway to identify more appropriate measures for dually eligible beneficiaries. The State expects to consult and cooperate with these efforts.

However there is also concern about the plethora of newly developing requirements from CMS Medicaid, CMS Medicare, demonstration evaluators, NCQA and NQF (MAP) and how they might relate to current D-SNP measures (Star Ratings, Structure and Process, HEDIS, CAHPs and others) and which of these D-SNP measures, if any, will be retained under the demonstration. The State lacks sufficient information on how all of these measurement efforts will be aligned and on when such information will be available which hampers its ability to move forward with an efficient measurement plan for the demonstration. Information must be received soon or it will be too difficult to align with current State efforts, consult with stakeholders, and address the State's interests in time to include clear expectations in development of the three-party 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 people with dual eligibility and are 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 (including relevant measures from other demonstration states) to identify areas in which the State could best focus efforts for this demonstration. The consultant will work with the State's Medical Director and will consult with the Health Services Advisory Committee, the SNBC Evaluation Workgroup and demonstration stakeholder groups including counties, current care systems, demonstration plans and long term care providers in developing final recommendations. 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.

A. 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 people with dual eligibility 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 XXII.A below, Barriers). Some utilization rates for people with disabilities enrolled in SNBC also indicate improvements when compared to FFS, 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 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>. In addition, as discussed in Section XIV and Section XXIII.D., the State will incorporate key elements of the Initiative to Reduce Avoidable Hospitalizations for Nursing Home Residents into the new ICSP purchasing models.

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.

XV. Medicare and Medicaid Data, Analytics and Capacity

The State will use a multi-level approach to data analysis, including feed-back reports to providers, data on HCH at the provider and ICSP level consistent with current HCH procedures, analysis of utilization and performance through encounters, analysis of demographic and geographic information, and analysis of other performance based information collected by DHS. Requirements for performance metrics will be designed to facilitate comparison of common utilization and quality measures with standardized reports, comparison of standard measures and common reporting periods across health plans and providers.

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 crossover 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 that CMS consider sharing State collected encounter data with CMS rather than having the MMICOs have to submit data to two different entities in 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 has contracted with JEN Associates Inc. for assistance in integrating Medicare and Medicaid FFS, encounter and enrollee assessment data and providing analytic tools for risk adjustment and standardized measurement for ongoing program metrics. Integrated Medicare and Medicaid encounter data, and other Medicaid data submissions are in the process of being prepared for use for the JEN data base. The contractor will also assist with necessary data requests to CMS for historical Medicare FFS 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 use 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. (See Appendix 3 for requests and recommendations on integration of overlapping Medicare and Medicaid requirements for quality improvement, reporting and oversight requirements.)

XVI. 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 demonstration contracts. All HIPAA 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 caregivers in care planning, including caregiver 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, minutes and results of followup to address any concerns expressed. While the MSHO/MS C+ 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 enrollee 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. (See Sections XXIII.C. for more information on current health literacy, language and reducing disparities 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 and will review current requirements and discuss with stakeholders groups to determine whether additional protections are needed.

An additional feature proposed in the demonstration contract is further protection against changes in medication access due to Enrollee changes in 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 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 at http://www.dhs.state.mn.us/dhs16_166538.pdf and 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 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 programs for people with dual eligibility. 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.

Please see Appendix 3 for additional proposals for streamlining reporting and oversight requirements.

XVII. 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. If MSC+ enrollees are included under the demonstration, the State will likely have to amend its 1915 (b)(c) waiver to reflect the changes in the population with appropriate public notice. In addition, the State seeks clarification on how the HCH benefit can be covered under Medicare instead of Medicaid for dually eligible enrollees and whether waivers would be required to accomplish this or whether this would remain a Medicaid benefit covered out of Medicare savings.

The State is not aware of any additional Medicaid waivers that would be required for implementation of this demonstration at this time. 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 with CMS. The State will provide appropriate public notice to tribes, the Medicaid Advisory Committee, Stakeholders groups, counties and the general public to implement any additional State Plan changes or waiver amendments that are determined necessary.

CMS has provided documents including a high level outline of additional Medicare flexibilities they are willing to entertain as part of the demonstration contracting process. While the outline does not address all operational and policy details for these demonstrations, we believe that Minnesota's proposal is compatible with those parameters. However, there are many details that still must be clarified for implementation. Appendix 3 includes a list of waivers of financial, technical and operational Medicare Advantage policies that will need to be addressed as part of the demonstration MOU development process 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. It should be noted that the State cannot anticipate all of the operational issues that might arise in implementation, so may need to request additional accommodation during the MOU process. 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. The State would like to work with CMS through the MOU on additional streamlining of reporting.

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.

XVIII. 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. The integrated demonstration would continue to operate under 1915(a)(c) and would continue to provide the same State Plan and waiver services for seniors. MSC+ would continue to operate under 1915(b)(c) for non-dually eligible seniors and those who choose not to enroll in the integrated demonstration with amendments as needed for any changes in the population. 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. The State seeks clarification as to whether that change requires a waiver request. 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. The State will provide any data on state supplemental payments such as DSH and UPL as required by CMS during the demonstration.

B. Existing Managed Care Programs

As described earlier, the State has several existing managed care programs especially designed for people with dual eligibility. 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 the new arrangements with MMICOs. The State would continue the MSC+ program and its corresponding 1915(b)(c) waiver for non-dually eligible seniors and for those who do not wish to enroll in the new integrated demonstration. It would also continue the SNBC program under 1915(a) for non-dually eligible people and any dually eligible members who opt out of the integrated Medicare/Medicaid demonstration.

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 XI.B.)

1. 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 County designed to integrate physical and mental health. The State would propose to continue this initiative and build upon it under the demonstration.

2. 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. However, providers previously interested in PACE sponsorship may find additional opportunities to participate under the new ICSP models in Section X.

3. 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. One of these efforts may focus on people with disabilities with complex medical needs and serious mental illness. The service delivery models proposed in this demonstration (such as *Model 3* in Section X) are designed to coordinate with that initiative, but some adjustments to the current Model of Care may be necessary as the project develops further.

4. Other CMS Demos

MAPCP: Minnesota is an all payer HCH state and one of eight participants in the MAPCP demonstration. However under the MAPCP demonstration Medicare provides health care home payments only to Medicare eligibles enrolled in FFS. 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, HCH should be a Medicare covered service for people with dual eligibility enrolled in managed care systems.

XIX. 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 which licenses, certifies and audits risk bearing entities (HMOs and county based purchasing entities (CBPs)) 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 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 its Director Mark Hudson, 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 Medical Director Dr. Jeff Schiff oversees medical policy for the Medicaid program.

Additional support is provided by the Continuing Care Administration through the SHIP's Senior Linkage Line as well as the Disability Linkage Line, which are both 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.

XX. Summary of Stakeholder Involvement

The State has conducted extensive efforts to involve affected stakeholders in the demonstration development process. A public website for the demonstration was established and materials and meeting schedules have been posted regularly. Approximately 56 workgroup meetings, trainings and/or presentations have been held using various stakeholder forums. See detailed documentation of stakeholders meetings provided in Appendix 4. The State has incorporated stakeholder feedback into the demonstration as the proposal has evolved through these discussions and maintains an ongoing effort to solicit broad input from the community.

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 heavily attended meetings have been held thus far for people with disabilities with an additional nine subgroup meetings and another nine for enrollment outreach. Three large group meetings have been held focusing on managed care for seniors. The State has also made an additional eighteen presentations to community and provider groups about the demonstration. A demonstration workgroup on Health Care Homes Communications has met twice thus far. In addition the State has had seven meetings with current managed care plans to discuss the demonstration, including a call with CMS with more meetings scheduled.

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 demonstration as well as the SNBC expansion (three meetings were held thus far with two more scheduled) and will continue regularly scheduled focused stakeholder group discussions with the tribes as the demonstration proceeds, including facilitated discussions with counties and MMICOs.

These stakeholder activities will continue. The Seniors' and Disability Stakeholder groups are meeting jointly on April 27, 2012 to discuss the final proposal submission where DHS will address questions and comments submitted during the public comment period. The two groups will continue to meet quarterly throughout the demonstration, with smaller subject matter breakout groups meeting as jointly determined by the group members 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 RFP

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, the seniors' contracts will be amended to require that all MMICOs also maintain these 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.

XXI. February 24, 2012 Public Comment and Letters of Support

In addition to the extensive stakeholder activity DHS published a draft of this proposal for a 30-day public comment period through the State Register on March 19, 2012 requesting input from consumers, family caregivers, advocates, providers and other stakeholders. A special email address was set up to receive comments. This email address will continue to be available for stakeholder communications throughout the demonstration (dual.demo@state.mn.us.) Public comments on the draft proposal were due April 19, 2012..

A letter of support from Governor Mark Dayton is provided in Appendix 6. The State received 26 additional separate letters of comment, many of which combined letters of support with constructive comments. Since it was not possible to separate the letters neatly into comments versus letters of support, and the number and length of comments were not overwhelming, copies of all of the comment letters are being provided in Appendix 6 of this proposal along with a cover memo identifying themes from the comments and areas of change in the proposal in response to the comments.

The majority of commenters expressed support for the demonstration's general direction and goals, though many raised implementation or policy issues that they want addressed. There was only one comment that did not want the demonstration to proceed. The State has incorporated some of the comments into this proposal and will continue to work with the commenters to clarify questions and address their many constructive suggestions. A meeting to discuss public comments and questions about the final proposal is scheduled for April 27, 2012. All commenters have been invited to participate.

XXII. Feasibility and Sustainability

A. Discussion of Barriers to Implementation

Minnesota's long experience in managing care within aligned Medicare and Medicaid financing has already produced increases in primary care visits, reductions in avoidable 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 one 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, disenrollment is under 3%. SNBC also performed better than FFS 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 the availability of 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. While some risk/gain based subcontracts are currently in place under current D-SNP arrangements 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 systems depending on provider interest.

Further, now that people with dual eligibility 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. However, 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.

XXIII. 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 Minnesota Heart Disease and Stroke Prevention 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. In addition, 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 CMS Partnership for Patients 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 X.

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/legislative rpt2011.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 MCO contracts require that the plans cooperate with this effort to retain and apply race and ethnicity data supplied by DHS needed for cross system measurements of disparities and related issues.

The four largest D-SNP plans participate in the Multilingual Health Resource Exchange, (www.health-exchange.net) a collaborative that shares the responsibility and cost of creating and distributing health education materials for non-English speaking patients and provides other resources to providers in communicating health information to their diverse patients. Three of the D-SNPs serving areas serving ethnically diverse members also participate in the MN Health Literacy Partnership which has three goals: training health care providers about health literacy, empowering patients to ask for clear communication, and sharing health literacy resources. (www.healthliteracymn.org.)

Plans have developed additional health literacy efforts which include hiring of Somali, Hmong, Russian and Spanish speaking care coordinators, systemic and measurable face to face collection and tracking of race and ethnicity data for use in communications and service delivery, translation and dissemination of health promotion, performance improvement and health prevention member materials into various languages including Somali and Russian, participation in community alliances to promote community health workers, formation of an Interpreting Stakeholder Group collaborative to promote quality and professionalism of interpreters, and bi-annual meetings for members with presentation on health literacy topics for diverse groups of seniors and/or people with disabilities.

One health plan (UCare) has also provided funding to the regional QIO (Stratis Health) for a focused online website and learning center called the Culture Care Connection (www.culturecareconnection.org). The site is designed to help health care providers, staff administrators and county agencies offer culturally and logistically appropriate care to the states growing multicultural population's in order to reduce healthcare disparities and achieve improved health care outcomes. The web site also has tools and resources that are specific, actionable and evidence-based.

D. Reducing Preventable Hospitalizations Among Nursing Facility Residents

The State has supported provider participation in CMS initiatives such as the post-acute bundling demonstrations designed to reduce nursing home resident hospitalizations. The State is also interested in the concepts included in the recently announced initiative to reduce avoidable hospitalizations among nursing home residents. However, CMS has clarified that these initiatives are designed for FFS residents in areas with high avoidable hospitalization rates. Most dually eligible seniors in Minnesota are already enrolled in integrated Medicare and Medicaid programs through current contracts with D-SNPs and would have to give up integrated Medicaid benefits, care coordination, waivers of three-day hospital stays, and other flexibilities and change their Part D coverage to participate in such initiatives as they are currently designed. In addition Minnesota already has one of the lowest rates of avoidable hospitalizations in the country for nursing home residents so may not be a priority area for CMS.

However, the State is interested in how it may incorporate such primary and long term care provider partnerships under the demonstration under *Model 2* as discussed in Section X. Some current plans and care systems already partner with long term care facilities (including gain sharing related to hospitalization rates) and some have had these arrangements for many years. The State also had long and effective experience with the Evercare model under MSHO until the Evercare organization closed its Minnesota operation in 2011. Other providers have developed similar models or their own versions of such care for this population. Under the demonstration, the State would be able to encourage primary care to partner with long term care providers to recreate similar effective models for nursing home residents.

XXIV. Implementation and Timelines

A. Implementation:

With its long history of managed health care programs for seniors and people with 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 intends to 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-party 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 eligible 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 would impair access to services. In the meantime, the State will develop its policies for ICSPs and will plan to issue an ICSP RFP in January 2013, with submissions due in March and 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 re-procure for SNBC for 2013 and would propose to combine that re-procurement with the joint State/CMS demonstration certification process.

B. Work Plan/Timeline Template

Timeframe	Key Activities/Milestones	Responsible Parties
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
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	PSD and legal counsel

Timeframe	Key Activities/Milestones	Responsible Parties
	SNPs	
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 three-party 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, MCO Ops 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 three-party 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 three-party contract negotiations and readiness review requirements met	CMS/DHS Leadership Team, legal counsel
June 2013	ICSP readiness reviews	MMICOs, PSD policy, Contract Compliance Unit, MCO Ops Unit
July 1, 2013	Implementation of ICSPs for senior population	PSD policy, Contract Compliance Unit, MCO Ops Unit
July 1, 2013	Implementation of SNBC population demonstration	PSD policy, Contract Compliance Unit, MCO Ops 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

XXV. CMS Implementation Support - Budget Request

Minnesota requests funding for the following elements to support the implementation of the demonstration proposal outlined in this document. The proposed budget of \$2,838,709 includes:

- Maintenance of the Medicare -Medicaid data base along with the development and implementation of automated provider reports, patient alerts and related communications.
- Actuarial analysis and rate setting.
- Program staff dedicated to responsibilities needed to successfully implement new demonstration features including project management and oversight, data analysis, development and implementation of ICSP contracting, additional enrollment resources and consumer choice counseling

- Program support which includes stakeholder meetings, provider and plan trainings and minimal IT system changes.
- Details of Minnesota's budget request for this demonstration can be found in Appendix 7.

XXVI. Table of Appendices

- 1. Appendix I: Related Purchasing Models**
- 2. Appendix 2: Summary Integrated Appeals Protocol**
- 3. Appendix 3: Payment and Operational Waivers, Requests and Recommendations**
- 4. Appendix 4: Stakeholder Input Summary**
- 5. Appendix 5: Current Performance Improvement Projects Summary**
- 6. Appendix 6: Comments and Letters of Support for this Proposal**
- 7. Appendix 7: CMS Implementation Support - Budget Request**