State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Minnesota

Summary: In 2011, Minnesota was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Minnesota Department of Human Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., May 31, 2012. You may submit comments on this proposal to MN-MedicareMedicaidCoordination@cms.hhs.gov.

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. HHSM-500-2011-00035c

April 26, 2012

Minnesota Department of Human Services

CMS DESIGN PROPOSAL

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

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Minnesota Department of Human Services

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 (rage 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.

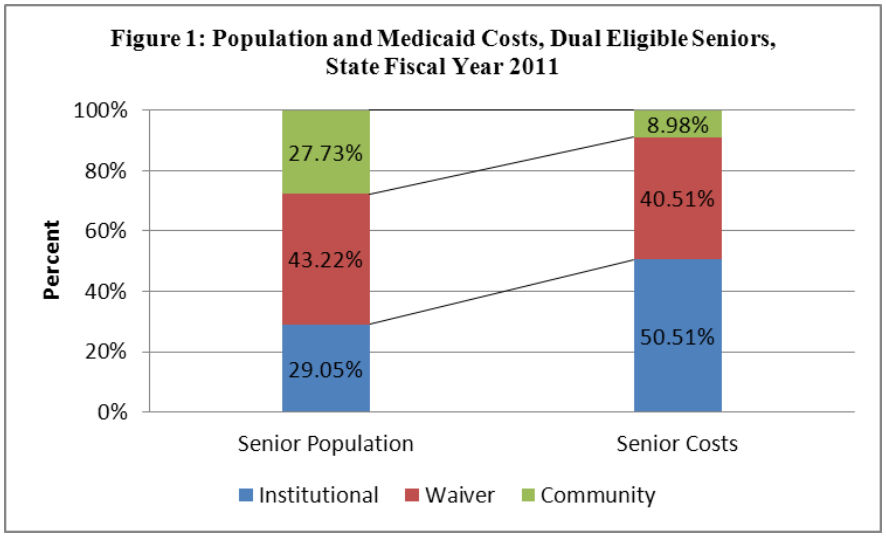
[11] Includes Corporate Adult Foster Care and Customized Living

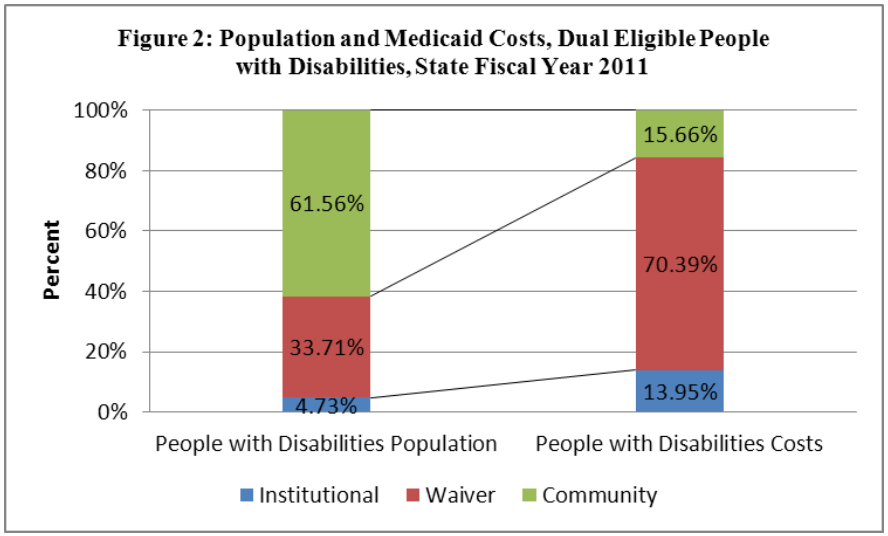
IV. Total Spending For Dually Eligible People In Minnesota

Table 4: Total Medicaid Costs[12] 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/MSC+ 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/MSC+ and SNBC contracts, unless alternative payment models have been negotiated (see *Models 2* and *3*). Risk and gain sharing is not required under *Model 1*. However, DHS will propose to CMS that HCH payments from MMICOs be considered an allowable cost 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 on-going 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/MSC+ programs also have advisory activities that include

members and or family members, the State intends to amend the senior's contracts to include a similar provision as part of this demonstration.

Contracts require collection of primary 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/legislativerpt2011.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. 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**
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5. **Appendix 5: Current Performance Improvement Projects Summary**
6. **Appendix 6: Comments and Letters of Support for this Proposal**

Appendix I: Related Purchasing Models

Current Programs Aligned Financing

CMS Medicare Contract and Payment to SNP
Medicare Primary and Acute Care

State Medicaid Contract and Payment to MCO/SNP
Medicaid State Plan and LTSS

MSC+ Un-managed Medicare

MSHO/SNBC SNP
SNP and Medicaid Requirements Pieced Together

PAC/NF

Mental Health

LTSS

Care Coordination
SNP/Counties/Tribes and Community Orgs

HCH or Clinics

Acute Care

Care Systems
Care Coordination payments to primary care providers

Sub-capitation or virtual caps for TCOC

Gain and risk sharing

Some include Mental Health or LTC providers

Enrollee choice of care system
Serves people in all settings

May or may not be HCH
Outcome measures set by SNP

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

Dual Demo Integrated Financing

4/23/2012

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

Virtual Care Systems
Communication Tools
Model 1

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

PAC/NF

LTSS

Care Coordination
MMICO/Counties/ Tribes/Community Organizations

HCH/Clinic and/or HH

Acute Care

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

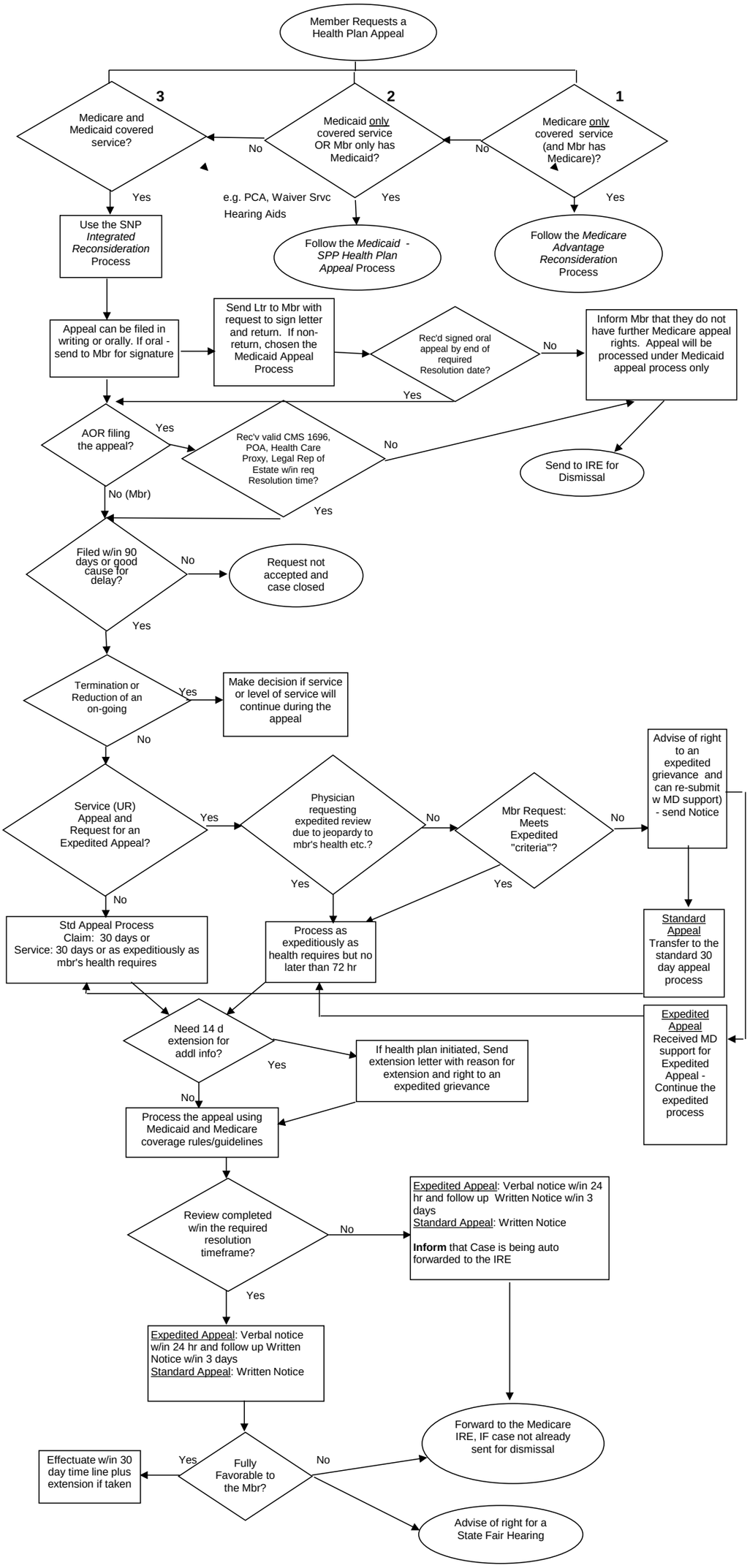
Model 2: Integrated Care System Partnerships (ICSP)
DHS establishes criteria for model options for ICSPs including:
-Primary care/payment reforms
-Integrated care delivery
-TCOC accountability and options for risk/gain sharing arrangements
--Opportunities for PAC/NF/LTSS/MH/CD providers
-HCH Certification/Transition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

Market Incentives and Stimulation

Appendix 2: Summary Integrated Appeals Protocol

Appendix 2: Integrated Appeals

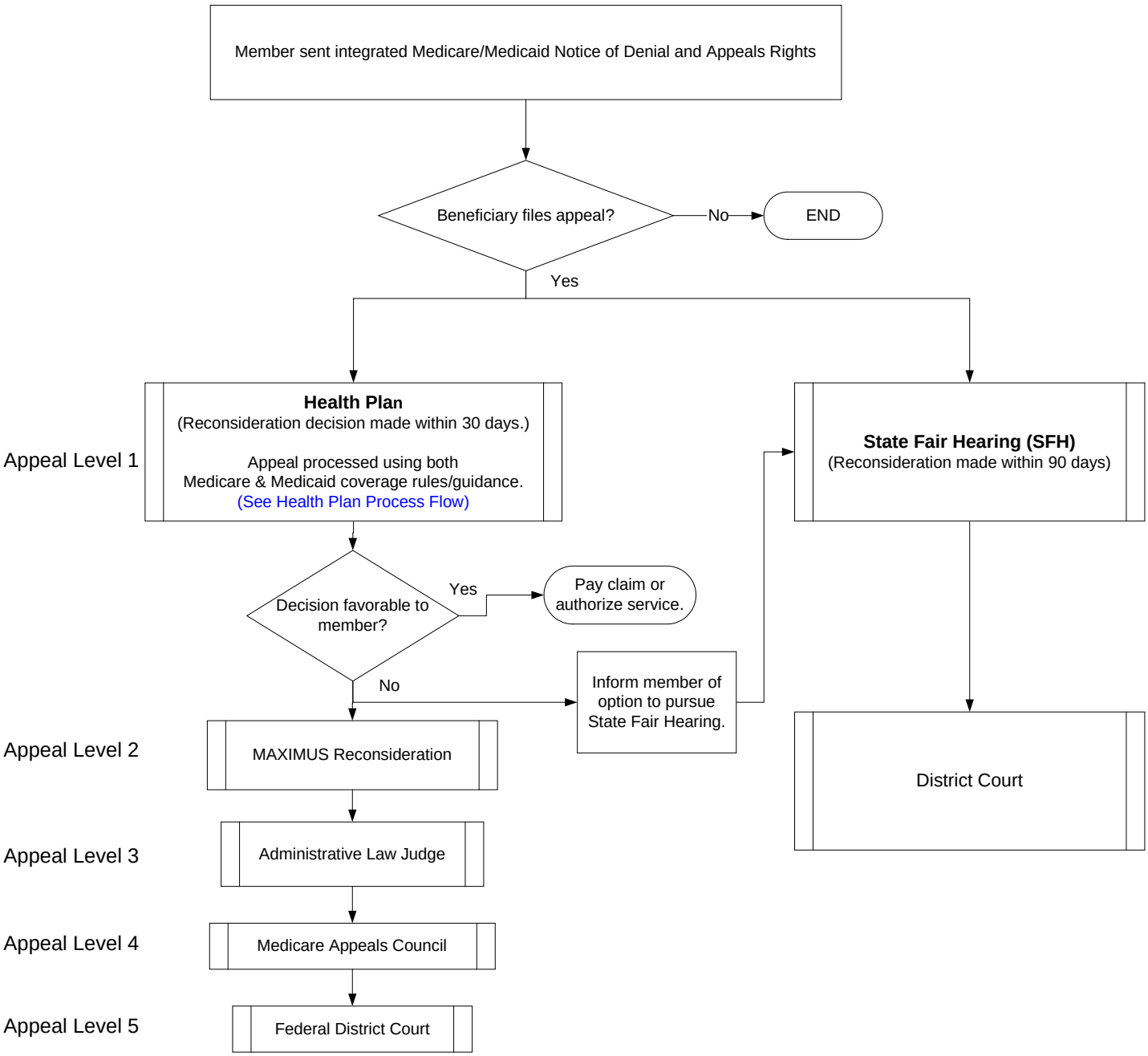
SNP Integrated Health Plan Appeals Process - 12/04/2007



Appendix 2: Integrated Appeals

SNP Integrated Appeal Process

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



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

Revised Nov. 12, 2007

Appendix 3: Payment and Operational Waivers, Requests and Recommendations

Appendix 3: Variances and Waivers Requested

While the State expects to be able to operate the demonstration within the parameters proposed by CMS in the January 29, 2012 guidance, that document did not include operational detail that may be necessary for implementation. The State provides the following list of items in which clarification may be needed during the implementation process on items already discussed, or in which waivers or variances from Medicaid managed care or Medicare Advantage procedures may be necessary. Most of these items are also noted in the proposal. Since we cannot anticipate all of the details absent more detailed discussions or guidance from CMS, this list may change as additional information becomes available.

H Numbers

1. The State appreciates CMS response to our request that demonstration plans also offering SNBC for people with disabilities be allowed to have separate H numbers for that product. We provide this rationale for why those H numbers are needed for CMS reference. SNBC has certain design features developed in conjunction with an active disability stakeholder oversight group based in state statutes which has strongly advocated for a disability specific focus for SNBC. In keeping with the need to separate oversight and reporting requirements for the two programs, the plans have had separate H numbers for the two products since SNBC began in 2008. While separate products may also be accommodated through the use of additional Plan Benefit Packages (PBPs) the State understands that many reporting and operational requirements are consolidated at the H number level, not the PBP level. Therefore separate H numbers would still be required for certain oversight and performance reporting in order to track and maintain differences related to the needs of each population.

Network Adequacy

1. The State requests that CMS deem existing D-SNP and MCO networks without resubmission of detailed HSD tables and contracting templates under the demonstration as part of the MMICO transition. The State and CMS have already approved the existing networks, CMS has accepted the current contracting templates and the State lacks the resources to re-review them. In addition, it is not clear how CMS automated review procedures will reflect provider availability and community standards in rural areas of the state. If current provider service patterns are not well reflected, a very large number of exceptions may result, creating unreasonable work load and burdens on CMS, the State and the plans for special review processes. Details on the CMS proposed exceptions review process have not yet been made available further limiting the time remaining for submission. In addition, detailed information must be collected and submitted on each provider including admitting privileges to hospitals, number of SNF beds, contract template cross references to Medicare authorities, and names of those authorized to sign contracts. If deeming is not acceptable, the State requests that the deadline time allowed for submission of these additional details be extended and that contract templates be submitted along with final signature pages which are due in the fall. Under current requirements that would remain in place, significant network changes (including 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.

Model of Care (MOC)

1. Deeming of Existing Submissions: As discussed with CMS, the State requests that CMS deem current MOC submitted by MSHO D-SNPs as meeting the demonstration's standards without requiring that current MOCs be re-viewed and scored. These MOC have already been approved by CMS and already reflect integrated care management policies consistent with State policy. The State is not proposing any immediate changes in its MOC policy at this time. Seven of eight participating demonstration plans have received three year approvals with one plan receiving a two year approval.

CMS has not yet made details of any new review process under the demonstration. There are many implications involved in the re-review of these MOCs since re-review could result in different scoring and/or raise issues for the State's current care coordination and long term care policies.

2. Multiple year Approvals: the State requests that current multi-year approvals be accepted under the demonstration.
3. If the State and CMS cannot reach agreement on demonstration implementation, the State requests that the current MOCs and multi-year approval status be retained for a transition back to D-SNP status.

Medicaid Formularies

1. The State requests that CMS accept current coordinated benefit determinations used by Minnesota D-SNPs in lieu of submission of all Medicaid drugs as Part D formulary supplements until such time that supplementary submissions can be made. Submission of the Medicaid formularies will take additional time because of the need for new PBM file formats and CMS policy changes for benzodiazepines and barbiturates which will result in new and complex Medicaid coverage policies for continued use of these under certain circumstances. The State is concerned that there is a lack of time for the State to develop and issue guidelines to the demonstration plans on the resultant Medicaid formulary changes prior to the required submission date.

Enrollment

1. Seamless Transition for Current MSHO and SNBC Medicare D-SNP Enrollees: The State requests that current D-SNP enrollees be seamlessly transitioned to the new demonstration in order to preserve their current primary care, care coordination, and Part D arrangements without disruption. The State and the MMICO (or the State, MMICO and CMS) would send each member a joint notice stating that their current health plan is transitioning to the demonstration's operational authority and that they do not need to take any action to remain in their health plan with continued Medicare and Medicaid services.
2. TPA Enrollment Function: The State requests to retain its current centralized enrollment function in which the State conducts enrollment functions for both Medicare and Medicaid acting on behalf of both the State and the health plans. Under this process enrollments would be conducted by the State. In addition, enrollment through Medicare.gov would not be allowed because it is not able to coordinate with the State's Medicaid enrollment system.
3. Opt Out Enrollment: The State requests that current and new MSC+ enrollees be enrolled in the demonstration after being given the option to opt out and remain in MSC+. Those who have opted out would be notified once each year at open enrollment of the opportunity to change their minds and enroll, however members would not be restricted from choosing to enroll at any time during the year. A similar policy would be followed for SNBC enrollees. Newly eligible enrollees for both groups would continue to be provided with opt out choices on a quarterly basis. The State may need to request additional adjustments once more information about opt out and enrollment processes is available.
4. Transition Policy: The State requests to retain the current SNP policy of allowing up to six months (in our case up to 90 days) of enrollment in the demonstration plan for member who have lost dual status so that they can transition to a new Part D plan. Many members lose Medicaid eligibility temporarily due to paper work issues but most are reinstated within 60-90 days. Currently these members stay in the plan for Medicare for up to 90 days, Medicaid ceases payment, plans continue services, and when eligibility is regained retroactively plan payments are also reinstated retroactively. If eligibility is not reinstated, members are disenrolled and there is no additional payment made to the plan. This

preserves continuity for the member and allows time to seek alternative Part D coverage for those who lose eligibility permanently.

5. Turning 65: The State requests that SNBC enrollees who turn 65 are allowed to remain in SNBC if they so choose (as is current policy), in order to preserve continuity of their care arrangements as under the current arrangement for D-SNPs.

Appeals and Grievances

1. Integrated Appeals Process: the State requests that it be allowed to follow its long standing integrated appeals process as outlined in Appendix 2. This process has been reviewed by CMS Medicare many times and we understand it to meet all Medicare requirements with the exception of a slight difference in Medicare timelines which should now be acceptable under the demonstration's announced parameters.
2. Language complexity: When integrating Medicare and Medicaid benefits, the current required DTR notice combining all Medicaid requirements with Medicare requirements gets very long. The State requests to work with the MMICOs and CMS to propose a shorter less confusing notice that retains all information members need for appeals.
3. Reporting of Appeals and Grievances: To the extent that there are separate requirements for reporting of grievances and appeals under current Part C reporting, the State requests that consolidation of this reporting be considered. Many Medicare and Medicaid services overlap. The State already collects extensive information about denials, terminations and reductions of service including grievances and appeals which could be shared with CMS.

Marketing/Beneficiary Information

1. Materials Review Process: The State requests that one centralized reviewer at the CO be assigned to approve materials for all dual demo participants to assure consistency and facilitate coordination of efficient reviews. In addition, the State requests that it determine which materials may be submitted as State approved models with file and use options, and when a State submitted model is used to reduce the timeline for to 10 days instead of 45.
2. Language: The State requests that CMS defer Medicare language block requirements to the State. New Medicare SNP requirements exclude five of the most used languages in Minnesota such as Somali and Hmong, but include other languages not relevant to this area of the country so would not meet the needs of our enrollees.
3. Currently Approved Materials: The State requests that currently approved materials under D-SNP "H" numbers be moved to new demonstration plan "H" numbers if necessary. In the meantime, the State along with the D-SNP workgroup will facilitate a review process to determine which if any materials must be modified and the timelines for such modifications as well as how such current approved model materials will be revised for the demonstration.
4. EOC/ANOC: The State requests that Medicaid information be integrated into the EOC using a model document developed by State and approved by CMS. However, due to the timing of legislative changes, the State may not be able to provide the detail of Medicaid benefits and policy changes in time for the October 1 deadline. For the same reason the State has not been able to include Medicaid information in the ANOC, so the State sends a separate notice of all Medicaid changes. The State proposes that the two documents remain separate unless timelines can be changed or a new process is worked out under the demonstration.
5. Skilled Nursing Facility Denials: 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, and this is upsetting and confusing to the enrollee. The State proposes that an integrated form be developed as a model document for use by all Minnesota demonstration plans.

6. Part D materials: Currently there is no clear process for altering or adapting Part D materials for integrated programs to make them accurate for dual eligibles. The State requests that it be allowed to work with the MMICOs to determine which materials need modification and to propose such modifications (including information about Medicaid formulary wrap arounds) for approval by the CMS RO.

Oversight, Monitoring, Reporting and Auditing

The State requests that CMS use this opportunity to streamline and consolidate oversight and monitoring of integrated Medicare/Medicaid managed care programs. As part of the MOU process the State proposes to work with CMS on details of this plan. Elements that should be considered at minimum are listed below.

- HOS: Since the State already requires the MCO to collect ADL and IADL data on enrollees and submit it to the State there is little value to having to conduct the HOS self-survey unless it is used for frailty factor purposes. The State requests that the HOS not be required under the demonstration unless the frailty factor is provided.
- Part C Reporting: The State requests that Part C reporting requirements not be applied to integrated demonstration programs or be substantially revised to ensure efficiency and alignment of requirements under both programs. Current reporting excludes Medicaid services so would not give a clear picture. In particular, the State would like to remove the Health Risk Assessment reporting process from these Part C requirements and integrate it with other State assessment reporting requirements. (See item 6 below). In addition, the State would like to explore whether demonstration plan hiring of independent data evaluators is still required under an integrated reporting system.
- Duplication of Medicare and Medicaid CAHPS: The State requests that the CAHPs requirement be combined for Medicare and Medicaid. The State conducts CAHPs at a more detailed program level than the CMS requirement and also includes additional questions on care coordination, so the State proposes to utilize its CAHPs in place of the CMS required CAHPs.
- HEDIS: Currently DHS collects and performs HEDIS analyses for all participating plans and reports this information publicly. In addition, each plan must report a set of HEDIS measures to the State licensing agency, the Minnesota Department of Health ,which also produces a report and submits information to NCQA. CMS also requires that HEDIS measures be collected. While DHS and MDH attempt to coordinate their HEDIS requirements with CMS requirements, these reporting requirements could be better aligned. The State proposes to work with CMS to consolidate reporting of HEDIS reporting in the most efficient manner.
- QIPs, CCIPs and PIPS: The State requests that PIPs, CCIPs and QIPs be combined under the demonstration. However the State wants to have a role in proposing and reviewing topics and results. Topics must leave room for State priorities such as issues specific to seniors (average age 80) including those with long term care needs as well as others which may be more relevant to people with disabilities and /or mental and chemical health conditions.
- CMS Audits: CMS should develop separate audit guides for the demonstration which should be specific to dual eligibles and different from those for regular SNPs and MA plans. States should be consulted on these guides and involved in the auditing process.
- Structure and Process Measures: The State requests clarification on the role of SNP Structure and Process Measures under the demonstration. Many of the S&P reporting requirements duplicate or overlap those in the MOC as well as some of the QIP and CCIP requirements. The State suggests that

these overlapping requirements could be consolidated under the demonstration and proposes to work with CMS during the MOU development on a streamlined process.

- Health Risk Assessment (HRA) and Transitions of Care Reporting: Reporting for these important elements is fragmented between CMS and the State, creating additional administrative complexity and barriers to measurement of outcomes. As part of the effort in item 6 above, the State proposes to review the Health Risk Assessment and Transitions of Care reporting processes and develop a plan to integrate them with current State reporting processes including links to reporting for long term care assessment and transitions from nursing homes under the State Money Follows the Person Demonstration.
- Performance Measures: The State requests that all performance measures to be applied to participating demonstration plans be reviewed and consolidated. A clear measurement template outlining all requirements should be developed that includes both Medicare and Medicaid priorities at both the CMS and State levels. There are so many measures to which the demonstration may be subject and such a lack of clarity over the role of the various measures that little sense can be made of the current measurement requirements. These include HEDIS and CAHPs, other current Medicare Advantage measures, specific SNP measures, Star Rating measures, current and potential CMS and State Medicaid long term care measures, CMS and State Medicaid managed care measures, new measures being proposed for dual eligibles by NQF and NCQA, evaluation measures being proposed by the evaluators, and countless additional measures in use specific to disease conditions or initiatives for reducing avoidable hospitalizations and improving care, many of which overlap and are duplicative.

Encounter Data Reporting

1. The State requests that CMS rely on the State's integrated encounter data reporting system for demonstration processes rather than creating a second encounter data reporting system for Medicare services. Since the State already collects all Medicaid and Medicare encounters, the State proposes to share its encounter data with CMS rather than having the MMICOs have to submit data to two different entities in two different formats. However, we understand that direct submission of Part D encounters to CMS would still be required.
2. Encounters should not have to be reported separately for Medicare and Medicaid services and reporting should be integrated.

Financing and Payments

1. The State has requested clarification from CMS on how Medicare baselines for savings scenarios and rates will be established. These clarifications and arrival at a viable Medicare/Medicaid financing model will be needed before contracts with MMICOs can move forward.
2. Withholds: DHS requests that performance based withholds under the demonstration be aligned with existing Medicaid withholds to the extent possible within current statutes with any new measures to be determined under the three-way contracting process.
3. HCC Risk Adjustment Model Improvements: The State requests that CMS apply proposed Medicare HCC risk model improvements to the demonstration, including the proposed change for dementia and the increase in number of conditions considered under the HCC model, both of which MedPAC has already recommended to Congress for implementation.
4. Risk/Gain Corridors: The State now includes a risk and gain sharing corridor arrangement in all SNBC contracts for non-SNP enrollees including dual eligibles. This mechanism is carefully designed to protect the State as well as the MCO. (See Section 4.1.2 of the SNBC contract.) We request that

CMS apply this risk and gain sharing plan to the entire integrated rate setting process for all people with disabilities enrolled under this demonstration.

5. CDPS for People with Disabilities: The State requests that CMS consider utilizing the CDPS risk adjustment model for both Medicare and Medicaid services for this population. The CDPS risk adjustment model is specifically designed for people with disabilities and has a more inclusive diagnostic algorithm than CMS' current Medicare risk adjustment system. The State is considering rebasing CDPS weights so CMS could work with the State to assure that weights are appropriate for both Medicare and Medicaid services. If the State's CDPS system is not utilized, the State requests that CMS implement the expanded diagnoses described above along with the new enrollee Medicare HCC risk model improvement which was found to be important for C-SNPs as studied by the General Accounting Office.

Supplemental Benefits

1. The State requests that it not be limited to current SNP policy outlined in the April 2 call letter regarding supplemental benefits. The benefits outlined there would be of no benefit to Minnesota, since all are currently covered by Medicaid. The State has already proposed one additional Medicare benefit (health care home) under the demonstration but the State does not consider that a "supplemental benefit" since it is within the scope of current primary care responsibilities as modified by already allowed payment reforms and best practices. The State and MMICOs will negotiate any additional supplemental benefit to be provided under the demonstration with CMS review.

Procurement

1. The State proposes to certify existing MSHO D-SNP sponsors as eligible participants under the demonstration for initial implementation. All MSHO plan sponsors already have been approved by CMS as SNPs and meet federal and State requirements to provide services. The State also intends to certify existing SNBC plans as eligible participants. However the State is required to conduct a periodic procurement of all products, and SNBC re-procurement is scheduled for later in 2012. The State will coordinate this SNBC procurement and the demonstration certification process with CMS for implementation for people with disabilities in the second phase of the demonstration.

Transition to SNP Status

1. The State requests assurances from CMS that it would facilitate transitions of demonstration plans back to D-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.

Appendix 4: Stakeholder Input Summary

Appendix 4. Documentation of Dual Demo Stakeholder Meetings

Stakeholder's Meetings for People with Disabilities in Managed Care

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

Seniors Managed Care Stakeholders Group

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

Joint Stakeholders Group (both Stakeholders groups above)

- April 27, 2012

Statewide Video Conference

- May 24, 2012 (3 hours AM, 3 hours PM)

Special Needs Plan Stakeholders Meetings

(In addition to monthly SNP meetings in which the dual demo was also discussed and Seniors and Disability Stakeholder meetings in which the SNPs also participate.)

- May 13, 2011
- September 15, 2011
- September 22, 2011 (included in CMS site visit)
- November 17, 2011
- February 15, 2012
- February 28, 2012
- April 11. 2012

Managed Care for People with Disabilities Outreach/Education

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

Focused training/presentation provided upon request

- August 12, 2011 Continuing Care Partners Panel:
- October 12, 2011 Maxis Mentor Group Video/webinar conference
- October 13, 2011 TBI DHS Policy Subcommittee

- October 20, 2011 Hennepin County Local Mental Health Advisory Council
- October 20, 2011, Disability Linkage Line MCOs /SNBC benefits
- November 5, NAMI conference workshop
- November 3, 2011; ARC Greater Area
- November 17, 2011: ARC West Central – webinar
- December 5, 2011: Commissioner's MA Reform Forum
- December 9, 2011: Continuing Care Partners Panel
- December 13, 2011: ARC Greater Twin Cities and Minnesota Consortium for Citizens with Disabilities
- January 4, 2012: DHS Brain Injury Advisory Committee
- February 7, 2012, County Managed Care Advocates, video conference
- January 18, 2012, DHS/SSA/DHS Quarterly Meeting,
- February 8, 2012 Aging Services of Minnesota Annual Conference workshop
- April 5, 2012 Mower County
- April 10, 2012 ARC Metro Area
- April 18, 2012 County Regions 4 and 5 (tele-conference)

Initial Topic Focus Stakeholders Workgroup Meetings
- October 18, 2011 Care Coordination/Transition Workgroup
- November 4, 2011 Managed Care 101 Training
- November 8, 2011 Consumer Education, Outreach, and Marketing:
- January 19, 2012 Evaluation Subgroup Initial Meeting

Follow Up Meetings of the above Topic Focus Stakeholder Workgroups
- February 16, 2012, Consumer Education, Involvement and Outreach:
- May 17, 2012 Evaluation Subgroup (scheduled)

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

MCO/CTY/Tribe Waiver Care Coordination Transitions and Communications
- November 15, 2011
- January 6, 2012
- March 29, 2012
- May 3, 2012 (scheduled)
- June 19, 2012 (scheduled)

Health Care Home Communications and Strategies Workgroup
- March 5, 2012
- March 20, 2012
- May 1, 2012 (scheduled)
- May 29, 2012 (scheduled)

Mental Health Targeted Case Management Communications
- May 2012 (scheduling in process)

Appendix 5: Current Performance Improvement Projects Summary

PIP News 2012

An Update for Professionals Working to Improve the Health of Patients Eligible for Public Programs in Minnesota

Participating Health Plans

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus)

HealthPartners

Medica

Metropolitan Health Plan (MHP)

UCare

Participating CBPs

Itasca Medical Care (IMCare)

PrimeWest Health (PrimeWest)

South Country Health Alliance (SCHA)

Stratis Health provides support and assistance to the health plans in developing, implementing, and evaluating the PIPs.

Health Improvement Projects (PIPs)

The Minnesota health plans and county based purchasing plans (CBPs) launch a performance improvement project (PIP) each year to improve the health of the public programs members they serve.

The participating health plans and CBPs develop and promote the performance improvement projects to comply with state requirements and support care coordinators and providers in their efforts to provide quality care in the complex arena of care for people eligible for public programs. Health plans are required to initiate a new performance improvement project each year with a typical cycle of two to four years. The Minnesota health plans and CBPs ("the collaborative") work together on the PIPs to align quality improvement efforts, provide consistent messages to providers, and collaborate to maximize impact. As such, some PIPs are completed as a collaborative effort across health plans.

This health plan collaborative performance improvement project (PIP) newsletter is designed to describe the current state public program PIPs and provide information about the PIPs that may be helpful for you in your work with public programs members.

In This Issue of PIP News

Minnesota Public Programs

MinnesotaCare (MNCare)	A publicly subsidized program for residents who do not have access to affordable health care coverage that serves an average of more than 100,000 people each month. It has been critical to helping people leave welfare to work, without losing health care coverage.
Prepaid Medical Assistance Program (PMAP)	A health care program that pays for medical services for low-income families, children, pregnant women, and people who have disabilities in Minnesota. This includes coverage for hospital stays, physician services, rehabilitation services, and preventive care.
Special Needs Basic Care (SNBC)	For people under age 65 who are certified disabled and eligible for Medical Assistance. The program also incorporates Medicare Parts A, B, and D for enrollees who have that coverage. Enrollees have a care coordinator for health care and support services. This program is available in most counties and is administered by DHS and contracted health plans. Enrollees get personal care assistance and private duty nursing services through DHS (fee for service).
Minnesota SeniorCare Plus (MSC+)	For low income seniors ages 65 and older and is provided through the health plan of choice, including a separate plan for Medicare Part D drug coverage, if the person has Medicare. Enrolling in MSC+ is mandatory unless the person is enrolled in the optional Minnesota Senior Health Options (MSHO) program.
The Minnesota Senior Health Options (MSHO)	Combines separate health programs and support systems into one health care package. It is for people ages 65 and older eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B or who have MA only. People can choose to join MSHO or stay in their current MA program. MSHO enrollees are assigned a care coordinator who will help them get their heath care and related support services.

Collaborative PIPs: Current Implementation

Topic	Timeline*	Populations	Plans
Colorectal Cancer (CRC) Screening**	2011-2014	PMAP, MNCare	Blue Plus, HealthPartners, Medica, UCare
Transitions in Care: improved post-discharge member follow-up care	2011-2014	SNBC, MSHO, MSC+	Blue Plus, HealthPartners, Medica, Metropolitan Health Plan
Blood pressure control for members with diabetes	2010-2013	PMAP, MNCare, SNBC, MSHO, MSC+	Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

***End date of implementation is estimated. If projects do not meet goals, implementation periods may be extended**
****UCare is also reaching the SNBC populations with the colorectal cancer (CRC) screening**

In 2011, the collaborative completed projects on aspirin therapy in ischemic heart disease and diabetes mellitus, human papillomavirus (HPV) vaccination, and preventive visits for new members.

In 2011, the CBPs launched organization-specific PIPs targeting the following areas:

- PrimeWest: Post-hospitalization follow-up for (MSHO, MSC+, PMAP), and cholesterol screening for members with diabetes (SNBC)
- IMCare: Asthma and COPD management (all populations)
- SCHA: Breast Cancer Screening (MSHO, MSC+, PMAP), Pneumococcal vaccination (SNBC)

Aspirin Therapy in Ischemic Heart Disease and Diabetes Mellitus

Participating Health Plans/CBPs

Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

Project Timeframe

2008 – 2011 (completed)

This PIP worked to promote awareness of the benefits of low-dose aspirin therapy in eligible MSHO/MSC+ members with a diagnosis of ischemic heart disease and/or diabetes mellitus. Prescriptions were tracked at the health plans through pharmacy claims allowing for measurement and monitoring of improvement. Project interventions included promoting communication between members and their care team regarding the use of aspirin therapy, as well as increasing awareness of Medicaid over-the-counter prescription benefits. Overall, the project promoted awareness of the use of clinical guidelines related to aspirin therapy.

Findings

As a result of this PIP, providers changed documentation of over-the-counter aspirin prescriptions to improve patient safety. This work has been successful, as the final measurement represents a 15.84% increase over the baseline measurement of 25.93%, well exceeding the 5% improvement goal. As a result of these results, this PIP has now been successfully completed.

David Pautz, MD, FACP, Senior Medical Director, Government Programs, Blue Plus, applauds the success of the project and attributes it to the work of the care coordinators: "Working with care coordinators to encourage and empower patients to talk with their health care provider about the health benefits of aspirin therapy and increasing awareness of over-the-counter benefits for aspirin helped ensure the success of this PIP."

What Can You Do?

Care coordinators: Continue to encourage conversations between patients and providers around low dose aspirin therapy.

Providers: Continue to prescribe low dose aspirin when appropriate to your patients.

For more information about this project, contact: Alisha Ellwood, alisha_ellwood@bluecrossmn.com**.**

Human Papillomavirus (HPV)

Participating Health Plans/CBPs

Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

Project Timeframe

2008 - 2010 (completed)

The overall project goal was to increase the rate of 11-12 year old females enrolled in PMAP or MNCare who received at least one administered dose of the HPV vaccine. Interventions included targeted materials to parents and guardians, as well as partnerships with physicians, clinics, and other key organizations to increase the awareness of the importance of HPV vaccination in the prevention of cervical cancer.

Findings to Date

The project exceeded its 5% improvement goal, moving the baseline rate from 23.84% to 32.60%.As a result, this PIP has now been successfully completed. The collaborative has integrated the successful interventions into regular business practices to sustain the improvements made.

What Can You Do?

Providers: Continue to encourage appropriate adolescents to receive the HPV vaccination.

Educational resources are available to download at: http://www.stratishealth.org/pip/hpv.html.

For more information about this project, contact: Bethany Krafthefer, bethany.krafthefer@primewest.org**.**

Preventive Visits for New Members

Participating CBPs (collaborative 1)

Itasca Medical Care, PrimeWest, South Country Health Alliance

Participating Health Plans (collaborative 2)

HealthPartners, Medica, Metropolitan Health Plan, UCare

Project Timeframe

2009 - 2011 (completed)

Two collaborative groups have been working on increasing the percentage of new members enrolled in MSHO, MSC+, PMAP, MNCare, or SNBC who receive a preventive visit within six months of enrollment.

Collaborative 1 has worked to promote member awareness through providing education and tools to providers and members on the benefits of receiving preventive visits. Clinics have been given information on appropriate coding for preventive visits. The collaborative has also been working to help improve communication between the health care team and members about the importance of a preventive visit. Additionally, the collaborative has provided assistance to members to overcome barriers to receiving a preventive visit, including providing an incentive for those members who complete a preventive visit.

Collaborative 2 has worked to promote the benefits of preventive care to new members through direct education and collaboration with providers, reinforcing the visit can serve to establish and maintain a relationship between the member and their care team.

Findings

The project has resulted in a small increase in preventive visits for new members according to the measurement criteria for the PIP. Additional data review by the teams indicates that many new members are accessing a primary care physician in the first six months of enrollment. However, coding practices may not reflect the visit included preventive information, or the member was 'new' as they may not have changed providers when they joined a new plan. Additional information to help improve coding of preventive visits and lessons learned through the PIP have been shared with the Department of Human Services and providers. The PIP has now been completed for both collaborative teams.

What Can You Do?

Care Coordinators: Work with members to determine if they are due for a preventive visit. Member materials have been created to assist in having these conversations: http://www.stratishealth.org/pip/preventive-care.html

Providers: Encourage and provide comprehensive preventative visits for members. Monitor coding to ensure these visits are indicated as preventive when appropriate.

For more information about this project, contact: Bethany Krafthefer, bethany.krafthefer@primewest.org, or Tamara Sippl, tsippl@ucare.org.

Blood Pressure Control for Members with Diabetes

Participating CBPs (collaborative 1)

Itasca Medical Care, PrimeWest, South Country Health Alliance

Participating Health Plans (collaborative 2)

Blue Plus, HealthPartners, Medica, Metropolitan Health Plan, UCare

Project Timeframe

2010 - 2013

Two collaborative groups continue to work on improving blood pressure control for members with diabetes enrolled in MSHO, MSC+, PMAP, MNCare, and SNBC. Both are working to increase the proportion of members with diabetes who have blood pressure in control as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care (CDC) <140/90 mmHg blood pressure measure.

The primary intervention strategy for collaborative 1 is a curriculum designed for members to promote learning by repetition, active participation, and interactive resources for questions or concerns. Members are also encouraged to have discussions with primary care providers. The topics are tailored to meet the unique needs of each population, with all materials emphasizing three key messages:

- Develop a blood pressure management plan with primary care provider
- Establish a blood pressure goal for each member
- Promote self monitoring of blood pressure at home or in the community

Each CBP has established a partnership with a champion clinic, nursing home, and SNBC support organization, taking a systematic approach toward managing blood pressure in patients with diabetes. The partnerships encourage individualized self-management approaches that empower patients. Effective strategies learned through these partnerships will be shared with providers in the CBP networks.

Interventions implemented by collaborative 2 include a variety of member, provider, and care coordinator outreach, including: two member postcards on self monitoring of blood pressure and questions to ask their doctor, member and provider letters encouraging enrollment in health plan medication therapy management programs, provider internet-based training series on four areas of hypertension management, and quality improvement initiatives with health plan partner clinics.

Findings to Date

Members participating in the collaborative 1 PIP were mailed a survey at the beginning of the project and again after the first year of interventions to gather information regarding blood pressure management knowledge and practices. There was an increase in both the number of members who reported having a conversation with their primary care provider

about blood pressure management and who had established a blood pressure goal. The number of members who report having a blood pressure goal increased by nearly 6% compared to baseline. More members also reported they monitor their blood pressure at home and most indicated they check their blood pressure themselves, although a growing number receive assistance from a family member. Educational materials reminded members of the various types of locations in the community that typically have blood pressure machines available for public use. The number of members reporting they knew where to could go in their own community to check their blood pressure increased by about 5%.

The first measurement period data from collaborative 2 shows an increase in the rate of members with controlled blood pressure. Data from the quality improvement initiatives with the collaborative 2 health plan partner clinics significantly improved in 2010.

What Can You Do?

Care Coordinators: Encourage members to set and monitor progress toward blood pressure management goals.

Providers: Encourage development and monitoring of blood pressure goals with all members as appropriate. Providers can refer patients to health plan disease management programs at any time for additional support and education. As part of their benefit coverage, most members can get a home blood pressure monitor through a prescription from their provider; most pharmacies and contracted medical equipment suppliers can dispense any brand or model that is certified for accuracy and best meets the needs of the patient.

For more information about this project, contact: Alice Laine (collaborative 1), ALaine@mnscha.org, or Sally Irrgang (collaborative 2), sally.irrgang@medica.com.

Colorectal Cancer Screening

Participating Health Plans

Blue Plus, Medica, HealthPartners, UCare

Project Timeframe

2011-2014

The goal of this PIP is to increase the colorectal cancer (CRC) screening rates of members enrolled in PMAP and MNCare at partner clinics by a relative improvement rate (RIR) of 15%. Each health plan is partnering with at least one clinic to promote awareness of CRC screening and improve clinic processes around CRC screening and tracking.

Interventions are specifically focused on the specific needs of the PMAP/MN Care population. Examples of improved clinic processes to improve rates in this population include outreach calls for patients overdue for screenings who had previously scheduled and cancelled. The health plans provide tools to promote CRC screening to patients from diverse backgrounds and are working to understand the role of interpretive services in CRC screening and availability of interpreters at specialty clinics because many CRC screens are completed at a site other than the primary care clinic. Interventions also include providing support for process improvement and technical assistance in the clinic, as well as training clinic staff to better understand and use the current CRC guidelines. Through this work, providers are annually tracking their overall and PMAP/MNCare CRC screening rates (e.g., discrete data collection in the EHR).

Findings to Date

The measure for this PIP is aligned with MN Community Measurement CRC measure specifications focusing on the PMAP/MNCare subset. All partner clinics reported baseline rates in the fall of 2011.

What Can You Do?

Care Coordinators: Educate members about the different CRC screening options. Encourage members to have conversations with their providers about the best options for screening.

Providers: Know your clinic's CRC screening rate. Look at your process to clarify how you are tracking on every patient regarding whether they've had a CRC screening completed. Develop processes to ensure your clinic/practitioners address the need for CRC screening with every patient.

For more information about this project, contact: Melissa Deuschle, mdeuschle@ucare.org**.**

Transitions in Care: Improved Post-Discharge Follow-Up Care

Participating Health Plans

Blue Plus, HealthPartners, Medica, Metropolitan Health Plan

Project Timeframe

2011 - 2014

This project works to increase the proportion of MSHO, MSC+, and SNBC members who complete a scheduled follow-up clinic appointment after hospital discharge. Success will be measured through claims that show a follow-up visit within 15 days of medical/surgical hospital discharge to home. The goal is to see a 14% relative improvement rate increase over baseline.

Each of the four participating health plans has partnered with a hospital and provider group to test interventions that encourage members to schedule and attend a follow-up clinic appointment after being discharged from the hospital. Interventions with the hospitals include reviewing and revising current processes, procedures, and tools around discharge planning, and improving provider engagement and ownership of the transition from the hospital to home.

Findings to Date

Hospital/clinic teams have reported on various evaluation metrics, member transition surveys have been administered, and initial lessons learned have been summarized. Initial feedback has been positive. The first measurement period timeframe (4/2011 - 3/2012) will be collected in spring 2012.

What Can You Do?

Care Coordinators: Work with members (MSHO, MSC+, SNBC) to ensure members schedule and attend their post-discharge follow-up appointment within 15 days of hospital discharge.

Providers: Follow transition and discharge processes to ensure follow-up clinic appointments are scheduled, that members receive adequate discharge instructions, and that necessary steps are taken to promote continuity and quality of care post-hospital discharge.

For more information about this project, contact: Barbara Post, barbara.post@co.hennepin.mn.us

Collaboration to Improve the Quality of Life for Members with Asthma or COPD

Participating Health Plans/CBPs:
Itasca Medical Care

Project Timeframe:
2011 - 2013

For this PIP, IMCare is collaborating with Grand Itasca Clinic & Hospital (GICH) to improve the quality of life of members with asthma/COPD. The study population includes the entire eligible MA/MSHO community population, ages 5 years and older. IMCare sent out a pre & post survey of all asthma & COPD members regarding their quality of life, and provided member education about symptom recognition, symptom control and self-management skills to help improve their quality of life. IMCare has also implemented and taught Pfizer's Beat the Pack smoking cessation program. IMCare has worked with the GICH quality department to send providers report cards of their members that meet defined criteria semi-annually. The goal of this PIP is to increase the percentage improvement in the total combined score of the symptom areas and self-management areas which contribute to the quality of life of our members with asthma/COPD, this is measured by the IMCare Asthma/COPD Quality of Life Member Survey.

Findings to Date
This PIP was initiated in January 2011. The Quality of Life survey will be resent to members in early 2012 to evaluate impact of the initiative.

What Can You Do?
Care coordinators and providers: Comprehensive high-quality care for those with asthma/COPD requires a collaborative effort. IMCare encourages our collaborative partners to discuss this project with IMCare members with asthma/COPD for whom they provide services; refer members to the smoking cessation program and disease management/case management programs as necessary.

For more information about this project, contact: Leah Huso, leah.huso@co.itasca.mn.us.

Cholesterol Screening Among Members with Diabetes

Participating CBP
PrimeWest

Project Timeframe
2011 - 2013

The purpose of this PIP is to increase the number of SNBC members ages 18-75 with diabetes who receive a low density lipoprotein-cholesterol (LDL-C), or "bad" cholesterol screening annually. The project will be considered successful when the HEDIS CDC rate for LDL-C screening reaches 85% or above and is sustained for two measurement periods.

Quarterly lists of members who have not received cholesterol screening ("risk lists") are emailed to County Case Managers to track cholesterol screening progress. To better understand issues of health care literacy, PrimeWest and its county case managers/care coordinators will focus on effective communication with members when sending reminders and during

face-to-face visits. PrimeWest communicates the project plan with providers that are secondarily involved, e.g., group homes, primary care provider clinics, care givers, etc. Reminders are sent to the primary care providers of the SNBC members in need of a cholesterol screening in efforts to have reminders placed into member charts.

Success/Findings to Date

Measurement period 1 rates will be available in July 2012.

What Can You Do?

Providers and Coordinators: Ensure all members with diabetes receive an annual LDL-C screening.

For more information about this project, contact: Bethany Krafthefer, bethany.krafthefer@primewest.org

Transitions of Care: Post-Discharge Member Follow-up

Participating CBP

PrimeWest

Project Timeframe

2011 - 2013

The purpose of this PIP is to facilitate coordination and information sharing with contracted focus hospitals to impact the outcomes of discharge planning for members, and to ultimately reduce readmissions. The project will be considered successful when the 30 day readmission rate for PrimeWest Health members discharged reaches a relative decrease of 10.8% from baseline and is sustained for two measurement periods in each population.

The main strategy of this project is to work closely with three focus hospitals to facilitate communication of the discharge date and discharge plan to PrimeWest, ideally to be provided within one day of a member being discharged from the hospital. A second strategy will be to use this information to reach out to members by making personal connections via phone call to let them know that support is available.

Interventions include evaluation of the focus hospital's existing discharge forms and communication practices. Discharged members receive timely follow-up communication related to the discharge plan. Understanding issues of health literacy, PrimeWest and its County Case Managers will focus on effective communication with members. The project plan and the related interventions are shared with those secondarily involved (pharmacies, PCP clinics, care givers, etc.). PrimeWest is tracking discharge and follow-up activities.

Findings to Date

Initial findings indicate that, overall, members are extremely surprised and pleased a PrimeWest nurse took time to call them to see how they were doing. Findings show the majority of members understood their discharge instructions and received a copy of these instructions. Members also scheduled and went to their follow-up visit.

PrimeWest has found there are challenges to receiving a discharge date and legible discharge instructions in a timely manner from the focus hospitals.

What Can You Do?

Care Coordinators: Work with members to ensure they received and understand their discharge instructions, and that they've scheduled and attended their follow-up visits.

Providers: Support the project by giving health plans timely notification of hospital discharges and giving members clear and understandable discharge instructions that include pertinent information such as:

- Hospital course and treatment
- Discharge medications
- Completed test results
- Pending test results
- Follow-up plans

For more information about this project, contact: Bethany Krafthefer, bethany.krafthefer@primewest.org**.**

Improving Influenza Vaccination Rates

Participating Health Plans

South Country Health Alliance

Project Timeframe

2011 - 2013

The goal of this project is to increase the number of SNBC members who receive an annual influenza shot.

Interventions are based on the Community Guide for Preventive Services, a model designed to provide population-based interventions to improve targeted vaccination coverage among these high-risk adults. Over the course of the flu season (September through March), all members—referred to as AbilityCare members—will receive up to two educational mailings about the importance of getting a flu shot, along with information about benefit coverage and how to obtain it. Members who don't get a flu shot after the two mailings will receive a follow-up phone call as a reminder, along with assistance for locating a flu shot clinic, scheduling an appointment, or arranging transportation.

All AbilityCare members will also be asked to complete a survey that identifies specific factors that influenced their decision to get the shot or not be immunized. Information gathered through this survey will be used for future intervention strategies and to refresh key messages.

Findings to Date

This PIP was initiated in August 2011, before the start of the 2011-2012 flu season. Process measures assessing the impact of specific interventions, as well as a review of claims data and calculation of the outcome measure, will be completed during 2nd Quarter 2012.

What Can You Do?

Care Coordinators and Providers: Both Care Coordinators and providers can help to promote flu shot clinics—including those hosted by public health departments—to clients/patients when possible and as appropriate. The flu shot is a covered benefit for SCHA members

For assistance finding a flu shot clinic or scheduling an appointment, members can contact SCHA's Member Services line toll-free at 1-866-567-7242 (TTY: 711) or visit MDH's "Find a Flu Shot Clinic" page: http://www.health.state.mn.us/cgi-bin/idepc/fluschedule/fluclinic_search.cgi.

Breast Cancer Screening

Participating CBP
South Country Health Alliance

Project Timeframe
2011 - 2013

The goal of project is to increase the proportion of SCHA's PMAP/MNCare, MSHO, and MSC+ members who receive a mammogram.

SCHA is taking a multi-faceted approach to improving compliance with mammography screening guidelines among women ages 42-69 years. As part of this PIP, eligible members are sent educational materials about the importance of breast cancer screenings, along with reminders to schedule a mammogram as they become due for the screening. Women who remain non-compliant are contacted via telephone and encouraged to complete the screening. SCHA also offers a reward to women who have a mammogram and return a voucher signed by a clinician. As part of SCHA's partnership with local public health departments, "risk lists" of members due for a mammogram are distributed to public health staff to provide additional outreach to women, including assistance with scheduling or transportation, as necessary. A survey of eligible SCHA members will also be employed to identify specific factors that either influenced the member to receive a mammogram or factors contributing to their lack of screening.

Findings to Date
This PIP was initiated in January 2011 and follows HEDIS measurement timelines. Process measures assessing the impact of specific interventions, as well as a review of claims data and calculation of the outcome measure, will be completed during 3rd Quarter 2012.

Providers and Coordinators: Support women who are appropriate for mammography to schedule and follow through with screening.

For more information on this project, contact: Alice Laine, alaine@mnscha.org.

2012 PIPs

A variety of projects are planned for launch in 2012. A brief summary of the 2012 PIP projects is outlined below.

Topic	Health Plan(s)	Population	Contact	
Reducing Non-Urgent Emergency Department Use in the PMAP/ MNCare Populations: A Partnership with the Minnesota Head Start Association	Blue Plus, HealthPartners, Medica, UCare	PMAP, MNCare	Alisha Ellwood	alisha_ellwood@bluecrossmn.com
Increasing use of Spirometry Testing for the Diagnosis of COPD in the MSHO/MSC+/ SNBC Populations	Blue Plus, HealthPartners, Medica	MSHO, MSC+, SNBC	Anne Wolf	Anne.e.wolf@healthpartners.com
Increasing Annual Preventive and Diagnostic Dental Services	Metropolitan Health Plan	MSHO, MSC+, SNBC	Monica Simmer	Monica.Simmer@co.hennepin.mn.us
Breast Cancer Screening	UCare	MSHO, MSC+, SNBC	Lindsay Kohn	lkohn@ucare.org
Colorectal Cancer Screening	Itasca Medical Care, PrimeWest Health, South Country Health Alliance	PMAP, MNCare, MSHO, MSC+, SNBC	Bethany Krafthefer	bethany.krafthefer@primewest.org

Questions

If you have additional questions regarding any of the initiatives, or would like to suggest topics for future newsletters, please feel free to contact the individuals listed under Plan Contacts. Thank you for all you do to improve quality of care for public programs members.

For more on the PIP work, please visit: http://www.stratishealth.org/providers/healthplanpips.html.

Plan Contacts

Blue Plus
Mary Henry
651-662-0826
Mary_R_Henry@bluecrossmn.com

HealthPartners
Anne Wolf
952-883-6000
Anne.e.wolf@healthpartners.com

Itasca Medical Care
Kathleen Anderson
1-800-843-9536, ext.2199
kathy.anderson@co.itasca.mn.us

Medica
Sally Irrgang
952-992-3835
sally.irrgang@medica.com

Metropolitan Health Plan (MHP)
Barbara Post
612-543-1343
barbara.post@co.hennepin.mn.us

PrimeWest Health
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South Country Health Alliance
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UCare
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Stratis Health
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Appendix 6: Comments and Letters of Support for this Proposal

Appendix 6. Summary of Public Comments

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I. Minnesota Design Proposal: Summary of Public Comments and Responses:

1. The State's Draft Proposal was published March 19 for a 31 day comment period ending April 19. A special email address was created for comments: dualdemo@state.mn.us.

2. In addition to the letter of support from Governor Mark Dayton, the State received 26 separate letters of support or comment submitted by 22 commenters. (Four sent both a letter of support and a comment letter.)

3. Seventeen letters expressed support. Eight of the commenters had mainly comments but did not state that they opposed the demonstration. Only one commenter stated opposition to the demonstration. All comments were insightful and constructive.

4. All letters of support and comments have been enclosed in this Appendix for CMS review. Because many letters combined support for the proposal with comments for both the State and CMS, they could not be easily separated. All letters and comments are also being posted on the State's website. Three individual commenters were contacted regarding privacy preferences and their personal identifying information has been removed at their request prior to submission.

5. The State has scheduled a Joint Dual Demonstration Stakeholders group meeting for April 27, 2012, 1-4 PM to discuss the final design proposal, answer questions that were raised by the commenters and discuss follow up steps. All commenters were sent emails inviting them to participate in this discussion.

6. The State has reviewed all comments and has grouped them into two general categories: comments that have been already been addressed or have been added to the proposal and those that require further discussion with Stakeholders and/or internal policy makers including a number that cannot be fully addressed until more information is available from CMS.

A. Breakdown of comments:

- Two individual consumers: one for, one against.
- One RN county case manager: supportive.
- Four consumer advocacy agencies (Minnesota Board on Aging, AARP, Legal Aid and MN Consortium for Citizens with Disabilities): all supportive with extensive comments.
- Five providers/care systems (Bluestone, Essentia, Fairview Partners, Axis Health Care, Courage Center): all supportive with comments.
- Mental Health provider consortium of six agencies: supportive with comments.
- LTC Imperative: sees positive potential, but many questions and comments.
- Minnesota Council of Health Plans (MHCP) plus additional letters from five individual health plans (Blues, Health Partners, Metropolitan Health Plan, Medica, UCare): four letters of support (three included additional comments), one conditional support with additional extensive comments, one extensive comment letter looking forward to further collaboration and participation.
- Hennepin County Public Health: supportive with comments.
- Two national pharmacy organizations: comments

B. Summary of Comment Highlights by Group

1. Minnesota Council of Health Plans and five participating HMOs (Blue Plus, Health Partners, Medica, Metropolitan Health Plan and UCare).
2. General support for integration and conceptual direction, willingness to work with State and CMS, opportunity to strengthen Triple Aim goals.
3. Great concern over lack of financial information about Medicare baselines and savings projections, baselines must reflect SGR restorations and realistic costs for high needs populations, one plan wants Medicare Advantage rates for 2013 (A).
4. Long history of program makes savings less possible (A).
5. Concerns about timelines and application process, support for deeming of networks and Models of Care, one plan wants delay to 2014 for seniors, another to 2014 for disabilities.
6. Demo plans must be more involved in demo development process with State and CMS.
7. Provider contracting relationships need to be partnerships with demo plans, more information needed on ICSPs, demo plans need to be involved in development and negotiations process of ICSPs since they will be holding the risk, number of ICSPs -- too many could increase administrative costs.

8. Need much flexibility in contracting and risk/gain arrangements to accommodate current systems and attract new care systems, concern that access/networks will be reduced if new contracting arrangements are unrealistic, don't disrupt current enrollee primary care.

9. Demo plans should be involved in letters sent re: transitions of current enrollees.

10. Not enough HCH out there to accommodate population, what kind of incentives for health care homes are envisioned, will they be accommodated in rates, communications methods must consider current HIT and software capabilities .

11. Consult plans in development of outcome measures, need flexibility to have some individual performance measures, measures need to be attainable, coordinate with other measurement efforts underway, concern over duplicative CMS/State withholds , duplicative measures, role of current SNP and Stars measures.

12. Streamlining of CMS and State administrative requirements needed

C. Disability Advocates, Consumers, and Providers

1. General support for MN unique approach of state/county managed LTSS with demo plan health care services, notes need for improvements in primary and preventive care for this population, need for Medicare to be part of the picture.

2. Two consumer stories illustrate problems with disintegrated care for people with disabilities, use of 4 cards to get care, confusing notices over drug coverage, difficulty for people with mental illness to understand, wants to go back to a more seamless program as they had before SNBC and MnDHO disintegrated or ceased.

3. Wants edits to document to note state/county management of LTSS, is already managed care for which State bears risk.

4. Amend proposal to emphasize unique legislated stakeholder role in creating SNBC from the start with ongoing oversight role, leading to current shared accountability design.

5. Provides reasons CMS should consider State's model of shared accountability for LTSS (consumers do not one entity in control of all services).

6. Note history of SNPs for people with disabilities in MN, and subsequent disintegration, concerns about adequacy of Medicare payments and risk adjustment for people with disabilities.

7. ICSPs cannot use attribution model, enrollees must choose primary care or be assigned to primary care system, with options to change systems monthly (as currently allowed).

8. Model 3 should not be limited only to people with SPMI, should be available to others with diagnoses of mental illness as well.

9. Over 50% of people with disabilities have at least one mental health/cognitive condition, involve mental health providers in ICSPs.

10. Supports pursuit of Health Home options.

11. More outcomes of care related to people with disabilities, more transparency for results and measures, collection of data on health and overall wellbeing, consumers should be involved in network accessibility standards vs self report from providers, look to work done in Oregon and Massachusetts, and MAPs, for appropriate measures for Minnesota, utilize SNBC Evaluation Workgroup as forum for that discussion.

12. Appeals chart is confusing, should use different terminology for HMO internal complaint process.

D. Senior Advocates (MBA, AARP)

1. Supports align incentives between Medicare and Medicaid as logical next step in Minnesota long history of integration.

2. Do not limit choice of primary care, allow choice to change.

3. Make sure design ensures that health care is not sole driver, but is part of the team so individualized long term care services are not over-medicalized.

4. Ensure that consumers retain current protections with seamless transitions, without care disruptions.

5. Support building on HCH and state reforms. Low Medicare payments pose challenge in Minnesota.

6. Financing should be transparent to consumers.

7. Model 1 supports having consumers choose HCH/primary care clinic if enough HCH and people can change clinics.

8. Model 2 risk sharing should be designed to avoid extreme profits or losses for MMICOs or providers, more details on roles and relationships of ICSP, providers and MMICOs.

9. Ensure seamless enrollment transitions for current enrollees, more information on enrollment outreach and education and protections for passive enrollment of MSC+ enrollees, especially around Part D changes.

10. More information on stakeholder involvement in measurement development.

11. Use demo as opportunity to address home care quality, MN ranks too high (37th in nation) on preventable hospitalizations for people getting home health services.

12. Assign one care coordinator to seniors, not multiple care coordinators. [This is already the policy for seniors].

13. Pay attention to upcoming Level of Care changes, strengthen transitions requirements for people moving to lower levels of service.

E. Hennepin County Public Health

1. Supports increased collaboration between LTSS, HCH and ICSPs under non-capitated model for people with disabilities, risk and gain models under SNBC, grandfathering of SNP info for application process.

2. MOU or legislation should be clear around risk and gain , should not cost shift to county safety net.

3. Reinvest any cost savings in improvements to primary care prevention.

4. More information on roles of ICSPs and MMICOs.

5. Make marketing rules less restrictive than current rules.

6. Involve counties in outcome measures and implementation.

F. Primary Care Provider Sponsored Care Systems

1. Support for risk and total cost of care models, are currently serving MSHO members, including care coordination and some risk for long term care services, for 5-15 years.

2. Outlines savings possible using waiver of 3 day stay, in-lieu of hospital payments to SNFs, onsite orthopedic care and non-traditional substitutions of services, indicates high satisfaction of members.

3. Financing needs to consider high risk of population served.

4. Concern over aggressive implementation dates given unknowns.

5. Concern that their own payment rates have declined while health plans administrative costs are rising.

6. Concern that frequent changes in expectations and measures decrease their ability to focus on care improvements and drives up care.

7. Allow care systems to manage benefits if they are providing positive outcomes at less cost.

8. Need for data transparency including claims and assessment data to providers, quality metrics by clinic/provider county, comparisons to baselines, regular reports provided.

9. Health plans should all use common utilization measures, definitions and reporting requirements.

10. Question as to whether ACO standards can be substituted for HCH certification.

11. What happens if no HCH homes available, or if provider is not yet HCH, do people remain where they are or have to change?

G. Long Term Care Imperative (LTC Provider Consortium)

1. Views demo as positive step with potential to improve on current MSHO program as long as it improves outcomes and is more efficient but has many questions.

2. How will payments be determined, who will determine payments? How much transparency will there be in plan payments? How will savings be distributed?

3. Will people opt out or be passively enrolled?

4. How will quality be measured and rewarded, who will determine measures?

5. Notes lack of discussion in proposal of funding and incentives for LTSS. There may be enough money in the system but distribution is too siloed. Need to use SNFs and home care as alternative to hospital and assisted living as alternative to nursing home and community services in place of assisted living.

6. State should consider elimination of the 180 cap on nursing home care paid under health plans and moving to site neutral payment system.

7. LTC providers need a seat at the table in payment and funding discussions. Move to payment systems that rewards care givers and invests in adequate staffing.

8. Flexibility needed in risk and reward options for different provider abilities.

9. DHS should play a role in the ICSP contracting, ICSPs may not work in all parts of the state, should reinvest in rural areas of the State where there is the most inefficiency.

10. Concept of having Medicare savings come to state is exciting, but should be used to invest in needs such as HIT for LTC providers, and adequate staffing.

11. How will this system be different from MSHO? More clarification on roles of counties, CBPs, ICSPs and demonstration plans though recognizes that some of the ambiguity may be related to differences in ICSP models.

H. Pharmacy Providers

1. Supports person centered care for dual eligibles, past integration efforts and building on Medicare Advantage Part D plans.

2. Concern about transitions of care for MSC+ and SNBC for pharmacy benefits for enrollment, wants outline of standards for assuring continuity of care for transitions.

3. Objects to large scale of Minnesota proposal, suggests it be done in one modest area as a pilot project with evaluation instead of permanent change.

4. Expand current Medicaid MTM service to duals, MTM services should be provided by local pharmacists for duals as part of this demonstration.

II. Summary of Responses to Comments and/or Changes to Document

1. Need for flexibility in contracting and risk/gain arrangements to accommodate current care systems and attract new ones, concern that access/networks will be reduced if new contracting arrangements are unrealistic. (M*ultiple models to meet varying needs are discussed in Section X and will continue to be discussed with Stakeholders.)*

2. Currently not enough HCH for all populations, will there be enough HCH, don't disrupt current enrollee primary care ,what happens if no HCH homes available, or if provider is not yet HCH, do people remain where they are or have to change? Supports having consumers choose HCH/primary care clinic if there are enough HCH and people can change clinics. (C*larified that*

enrollees stay in current arrangements until new arrangements are available to avoid disruption in Section X,)

3. Make sure design ensures that health care is not sole driver, but is part of the team so individualized long term care services are not over-medicalized. (W*ill be further addressed in development of ICSPs, clarified need for partnerships between primary care and long term care in Section X)*

4. Ensure that consumers retain current protections with seamless transitions, without care disruptions. (*BBA and Medicare Advantage protections provided under managed care regulations will continue under the demonstration, see Section XVI).*

5. Clarified that state/county management of LTSS for people with disabilities is already fully capped and managed system for which State bears risk (Section XI B).

6. Clarified unique legislated stakeholder role in creating SNBC from the start with ongoing oversight role, leading to current shared accountability design (Section XI B).

7. ICSPs should not use "attribution" model due to need for ongoing care coordination relationships, enrollees will choose primary care or be assigned to primary care system with options to change systems monthly (Clarified in Section X B.2).

8. Provide more transparency for results and measures, look at OR, MA and MAPs for appropriate measures for Minnesota, utilize SNBC Evaluation Workgroup as forum for that discussion. *(Clarified in Section XIV.)*

9. Assign one care coordinator to seniors, not multiple care coordinators. *(Clarified that this is already the policy for seniors and will continue, Section X. A.)*

10. Strengthen transitions requirements for people moving to lower levels of service due to proposed Level of Care changes. (Added to Section X.)

11. HCH communications methods must consider current HIT and software capabilities. (*Clarification in Section X B. I.).*

12. Model 3 should not be limited only to people with SPMI, should be available to others with diagnoses of mental illness as well. (C*larified that model is not restricted to serious and persistent mental illness diagnoses, could be adapted to other disability groups with co-occurring mental illness/cognitive impairment, further discussion on this with CHM and CC is in progress, Section X B.4.)*

13. How will quality be measured and rewarded, who will determine measures? Consult current plans and providers in development of outcome measures, need flexibility to have some individual performance measures, measures need to be attainable, health plans should all use common utilization measures, definitions and reporting requirements, provide more information on stakeholder involvement in measurement development, involve counties, care systems, long term care providers, consumers, plans in outcome measures and implementation. (C*larified further stakeholder involvement in measurement in Section XIV, including need to have more information about CMS required measures before we can finalize state measurement plans.)*

14. Concern about short CMS application timelines and continued SNP requirements, duplication of Medicare and Medicaid requirements, concern that current plans must be more involved in

discussions, questions about three-party contracting process. *(Addressed in Appendix 3 follow up discussions with plans and CMS being scheduled.)*

15. Need for data transparency including claims and assessment data to providers, quality metrics by clinic/provider county, comparisons to baselines, regular reports provided to providers. (*Clarified in XV).*

16. Reinvest any cost savings in improvements to primary care prevention. *(Section XI: the State has proposed to cover HCH payments out of Medicare savings.)*

17. Clarified that demo plans should be involved in letters sent re: transitions of current enrollees. (*Section VI*)

18. Provide outline of standards for assuring continuity of care for transitions around Part D changes. *(Clarified that we will examine current Part D continuity requirements to determine any additional needs and discuss with stakeholders, in VI.)*

19. What kind of incentives for health care homes are envisioned, will they be accommodated in rates*? (This was not meant to require payments beyond current required HCH payment but demonstration plans should also explore additional means of encouraging clinics to become certified HCHs. Changed 'incentives" to "encourage" in X.)*

20. One plan wants Medicare Advantage rates for 2013 and delay to 2014 for implementation for Seniors. (*Implementation date is still contingent on financing model being viable for Minnesota, further discussions with plans are being scheduled.)*

21. One plan wants delay to 2014 for people with disabilities. *(Discussing timelines further with plans and CMS.)*

22. Concern that provider payment rates have declined while health plans administrative costs are rising. (T*he Minnesota legislature has made a number of cuts in provider rates in recent years but has also capped administrative costs for health plans at 6.2%.)*

23. Objects to large scale of Minnesota proposal, suggests it be done in one modest geographic area as a pilot project with evaluation instead of permanent change. *(Comment is from out of state pharmacy provider group, notes change in Part D plans for people enrolled in demonstration, but MN has had statewide integrated system for seniors since 2005 and for people with disabilities since 2008, so demonstration is in fact not a large change for MN. A move to a pilot would be a step backwards for integration in MN.)*

III. Summary of Comments Requiring Further Follow Up

1. Provider contracting relationships need to be partnerships with demo plans, more information needed on ICSPs, demo plans need to be involved in development and negotiations process of ICSPs since they will be holding the risk, will there be limits on number of ICSPs-too many could increase administrative costs. *(Will continue to discuss further with demonstration plans and providers.)*

2. More clarification on payment for and roles of counties, CBPs, ICSPs and MMICO demonstration plans. *(Models are evolving, will continue to discuss with stakeholders, some clarifications added to Section X.)*

3. How will payments be determined, who will determine payments? How much transparency will there be in plan payments? How will savings be distributed? (*Need more information on financial/rates models from CMS before we can design payment models and provide answers to these questions.)*

4. State should consider elimination of the 180 cap on nursing home care paid under health plans and moving to site neutral payment system. *(Would require legislation, will discuss further with Continuing Care, Budget officials and long term care providers.)*

5. Can ACO standards can be substituted for HCH certification.*(Requires further discussion.)*

6. Demo plans must be more involved in demo development process with State and CMS. (*Will address directly with plans and CMS in upcoming calls.)*

7. Appeals chart is confusing, should not use "appeal" terminology for Medicare HMO internal complaint process. *(Removed "Grievance" in title of Appendix 2, have offered to follow up with commenter.)*

8. Use demo as opportunity to address home care quality, MN ranks too high (37th in nation) on preventable hospitalizations for people getting home health services. *(Have referred issue to Continuing Care for follow up.)*

9. Should collect more data on health and overall wellbeing of people with disabilities. *(DHS collects more data than the public is likely aware, will discuss with Stakeholders group. CMS is planning data collection so is difficult to move forward until those requirements are clarified . Will share available information on CMS evaluation with Stakeholders and discuss further in next SNBC Evaluation Workgroup scheduled for May 17.)*

10. Need to use SNFs and home care as alternative to hospital and assisted living as alternative to nursing home and community services in place of assisted living. *(Agree; will share best practices in Stakeholders meeting.)*

11. LTC providers need a seat at the table in payment and funding discussions. *(LTC providers are included in the Stakeholders groups, Section X clarified re: partnerships with LTC providers.)*

12. Move to payment systems that rewards care givers and invests in adequate staffing. *(Requires follow up discussion.)*

13. Should reinvest savings in rural areas of the State where there is the most inefficiency. *(Requires follow up discussion.)*

14. Invest in needs such as HIT for LTC providers, and adequate staffing. *(Discuss internally at DHS.)*

15. Expand current Medicaid MTM service to duals, MTM services should be provided by local pharmacists for duals as part of this demonstration. *(Part D is not changing. MTM is a Part D covered service, so would be a cost to the State to cover it under Medicaid for duals.)*

16. MOU or legislation should be clear around risk and gain, should not result in cost shift to county safety net. *(Agree, will have follow up discussion.)*

Letters of Support and/or Comments

Governor Dayton
Nancy Ekola
Anonymous Commenter
Anonymous County Nurse
Minnesota Board on Aging
Minnesota AARP
Minnesota Disability Law Center #1
Minnesota Disability Law Center #2
Consortium for Citizens with Disabilities
AXIS Healthcare
Bluestone Physician Services
Courage Center
Essentia Health #1
Essentia Health #2
Fairview Partners #1
Fairview Partners #2
Six Mental Health Provider Agencies
The Long-Term Care Imperative
Minnesota Council of Health Plans
Blue Plus
HealthPartners #1
HealthPartners #2
Metropolitan Health Plan
Medica
UCare #1
UCare #2
Hennepin County Human Services and Public Health Department
PhRMA
National Association of Chain Drug Stores