Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Idaho

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. 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 the selected financial model(s). The Idaho Department of Health and Welfare 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. EDT, June 30, 2012. You may submit comments on this proposal to ID-MedicareMedicaidCoordination@cms.hhs.gov.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Idaho Division of Medicaid

Demonstration Proposal to Integrate Care for Dual Eligibles

May 2012

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A. Executive Summary

The State of Idaho intends to participate in the Demonstration to Integrate Care for Dual Eligible Individuals. The goal of this initiative is to integrate and coordinate care for all full-benefit Medicare-Medicaid enrollees ("dual eligibles") living anywhere in the State, in order to improve their health and quality of life. Idaho Medicaid's participation reflects a desire to improve the quality and cost-effectiveness of care for this vulnerable population. Further, this proposal responds to the Idaho Legislature's direction in House Bill 260 to develop a managed care plan for dual eligibles that will result in an accountable care system with improved health outcomes.

Dual eligibles often have difficulty navigating the complex Medicare and Medicaid systems to properly address their extensive medical needs, frequent care transitions, and interactions with multiple providers and provider types in various settings. Many complications arise because Medicare and Medicaid were not designed with an intention to serve people in both programs in a coordinated manner. As a result, there are different Medicare and Medicaid rules and processes for enrollment, benefits, appeals, administration, marketing, financing, and more. This current state of misalignment means that dual eligibles can greatly benefit from an approach under which one entity coordinates their full range of interactions with the health care system.

Consequently, Idaho intends to enter into a three-way, three-year contract with CMS and health plans (managed care organizations) to provide integrated, comprehensive, seamless coverage to dual eligibles. The new, integrated delivery system will align the care delivery model and payment methodology to ensure high-quality, efficient care that leads to better health for Idaho's 17,735 dual eligible citizens. The contracts will require the health plans to ensure that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-term supports and services) are provided, coordinated, and managed. The beneficiary will have an integrated set of benefits, one process for resolving disputes, and one entity responsible for coordinating the provision of high-quality, efficient care. For those individuals who qualify for a health home under Section C(e) of this proposal, health plans will contract directly with the health homes, which will continue to provide care management and coordination.

The contracts will build in financial incentives which align the interests of the health plans and the beneficiaries. Health plans will maximize their success only by offering excellent care to beneficiaries. Payments to health plans will be blended capitation payments based on an actuarial analysis of historical costs and projected costs for duals' Medicare and Medicaid services. Payments will not be increased or decreased based on actual expenditures during this demonstration. Payments will be adjusted, however, based on health plan performance with respect to quality measures.

Dual eligibles are currently able to opt into a Medicare-Medicaid Coordinated Plan (MMCP) made available under the authority of §1937 of the Social Security Act. This program covers and coordinates Medicare and many Medicaid services, and it will continue unchanged through the end of 2013. Starting on January 1, 2014, Idaho will replace the current MMCP with the new coordinated program. The new program will utilize mandatory enrollment into health plans under concurrent §1915(b)/ §1915(c) Social Security Act authority for Medicaid plan benefits,

and passive enrollment with an opt-out provision for Medicare benefits. This has been determined to be the most effective way to ensure quality, coordinated care for all full dual eligibles in Idaho. Beneficiary choices and protections are a priority, as people will have the right to choose from at least two plans, change plans, self-direct care, choose from available providers within the plan's network, appeal health plan decisions, opt out of the Medicare component of the plan, etc. Additionally, stakeholder involvement and input has been, and will continue to be, a vital component of the development of the program (see Section D).

TABLE A: **Summary of the Idaho Initiative to Integrate Care for Dual Eligibles**

Target Population	All full benefit Medicare-Medicaid enrollees
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	17,735 – as of March 2012
Total Number of Beneficiaries Eligible for Demonstration	17,735 – as of March 2012
Geographic Service Area	Statewide
Summary of Covered Medicaid Benefits through Coordinated Plans - 2014	All Medicaid services will be available to qualifying participants including State Plan, Basic Plan, Enhanced Plan and HCBS waiver services based on their needs. **HOSPITAL SERVICES:** Inpatient Outpatient **LONG-TERM CARE SERVICES:** Nursing Facilities Personal Care Services Home Health Aged and Disabled Waiver Services Developmental Disability Waiver Services **PHARMACY SERVICES:** Prescription Drugs; Medicare-covered Drugs Medicare Part D Excluded Drugs Covered by Medicaid **MEDICAL SERVICES:** Physician Services Other Practitioners Lab & Radiological Services Federally Qualified Health Centers Rural Health Clinics Ambulatory Surgical Centers Preventive Health Assistance Family Planning Emergency Room Services Therapy Services

	Speech, Hearing, and Language Services Medical Equipment and Supplies Prosthetic Devices Specialized Medical Equipment and Supplies **DENTAL SERVICES** **DEVELOPMENTAL DISABILITY SERVICES** DD Waiver Services (mentioned above) ICF/ID Services Dev. Disability Agency Services **VISION SERVICES** **MENTAL HEALTH SERVICES** Inpatient Psychiatric Services Outpatient Mental Health Services **OTHER SERVICES** Primary care case management Indian Health Services Medical Transportation
Summary of Stakeholder Engagement/Input	9/26/11 – Meeting with 5 health plans: Blue Cross of Idaho, United HealthCare, Pacific Source, Regence Blue Shield, and Sterling Health Plans. 10/26/11 – Meeting with more than 50 stakeholders statewide via teleconference. 11/18/11 – Oregon and Utah presentations on their managed care challenges and successes to Idaho Legislature 12/2/11 – First of five ongoing monthly meetings with health plans 12/13/11 – Public forum held with panel presentations from hospitals, community health centers, and physicians. 2/16/12 – Managed care presentation to Idaho Senate committee members 2/24/12 – Managed care presentation to Idaho House committee members 3/15/12 Proposal brief posted on website 4/17/12 – Statewide stakeholder videoconference on proposal 5/25/12 – Webinar presentation available statewide for all stakeholders to discuss input received and changes incorporated into the draft proposal since the prior meeting 2012 - Quarterly Personal Assistance Oversight (PAO) committee meetings, quarterly Medical Care Advisory Committee (MCAC) meetings, and Nursing Facility Prospective Payment System meetings

Financing Model	Full Capitation
Proposed Implementation Date(s)	January 1, 2014

B. Background

The dual eligible population is comprised of people who are among the nation's most chronically ill and costly individuals. Most dual eligible beneficiaries receive fragmented, poorly coordinated, and disproportionately expensive care as they attempt to navigate through the complexities of the Medicare and Medicaid systems. Dual eligibles account for just 21% of the Medicare population, but 36% of Medicare fee-for-service spending. They account for only 15% of the Medicaid population, but 39% of Medicaid spending.[1] Medicare and Medicaid services are not coordinated for the large majority of dual eligibles in the State.

To address these issues, Idaho Medicaid currently offers a Medicare-Medicaid Coordinated Plan (MMCP) for dual eligible individuals. Enrollees participate in a Medicare Advantage plan offered by Blue Cross of Idaho. The MMCP permits dual eligibles to voluntarily enroll in a health plan that receives capitation payments to deliver both Medicaid and Medicare services to the enrollees. The MMCP offers Medicare services and certain Medicaid-covered services, including but not limited to hospital inpatient and outpatient services, emergency room services, ambulatory surgical center services, physician services, other practitioner services, prevention services, laboratory and radiological services, prescribed drugs, family planning services, inpatient psychiatric services, outpatient mental health services, home health care, therapy services, speech, hearing, and language services, medical equipment and supplies, prosthetic devices, vision services, dental services, primary care case management, prevention and health assistance benefits, Medicare Part D excluded drugs covered by Medicaid, specialized medical equipment and supplies, dentures, rural health clinic services, federally qualified health center services, and Indian health clinic services.

Care for these individuals in the MMCP is better coordinated and more cost-effective, as evidenced by their average of $1,500 of monthly expenditures for included services, compared to $1,800 for the same services for dual eligibles not in the MMCP.[2] These expenditure levels are likely to change, as only some Medicaid services are currently covered. As of March 2012, only 604 of 17,735 dual eligibles, or 3.4% of the total, were enrolled in the MMCP. In other words, the large majority of dual eligibles in Idaho continue to receive no coordination between their Medicare and Medicaid services.

The Idaho Medicaid State Plan is made up of the "Standard" State Plan which includes mandatory minimum benefits and three "Benchmark" plans that are aligned with health needs and include an emphasis on prevention and wellness. During the eligibility process, Medicaid applicants are offered the choice of the standard plan or a preferred benchmark plan. Benchmarks are the preferred plans because they offer more benefits designed to meet the health needs of the individual. Most applicants will have a choice of the standard plan or the Basic Plan.

[1] "Integrating Care for Medicare-Medicaid Enrollees." Centers for Medicare and Medicaid Services. http://www.cms.gov/medicare-medicaid-coordination/downloads/MedicareMedicaidCoordinationOfficeGeneralPresentation.pdf.

[2] http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCareManagedCare/tabid/1910/Default.aspx

Only individuals who have disabilities or special needs can choose between the standard plan and the enhanced plan. Plan changes can be made after enrollment based on changes in health status. The Medicare/Medicaid plan choice is designed specifically for individuals who have both Medicare and Medicaid coverage.

Idaho Medicaid does offer a primary care case management program, Healthy Connections, to Medicaid participants. Healthy Connections is a program by which health care services are provided through a single point of entry into the system, the person's primary care provider (PCP). The PCP, in addition to providing care, makes referrals to other providers when care is needed that he or she cannot provide. However, Healthy Connections only applies to Medicaid services. It does not help with coordination of Medicare services, and it does not coordinate services between Medicare and Medicaid. It does not resolve the misalignment between Medicare and Medicaid, or any of problems associated with that misalignment. It does, however, help to provide improved management of care for dual eligibles' Medicaid services.

Dual eligibles in the MMCP and Healthy Connections programs will not see a change in their programs through the end of 2013. Starting in 2014, however, the coordinated care program will address the low MMCP participation by using a mandatory enrollment process into the new, coordinated health plans, under concurrent §1915(b)/§1915(c) Social Security Act authority. Duals currently in the MMCP will see improved, comprehensive care coordination in the new program. Dual eligibles currently in Healthy Connections and duals in neither the MMCP nor Healthy Connections will have their Medicare and Medicaid services coordinated for the first time.

Also for the first time, Idaho Medicaid will offer the full spectrum of Medicare and Medicaid benefits through the new, coordinated health plans. The current MMCP does not cover certain Medicaid waiver services, including long term care services, personal care services, psychosocial rehabilitation, and developmental disability services. This leads to service fragmentation even for participants in the MMCP, as some of their Medicaid services are still available outside the plans provisions on a fee-for-service basis. This problem will be eliminated in 2014 because the State will require participating health plans to cover and coordinate all Medicaid and Medicare services. Participants will not necessarily receive any new benefits which are not already available to them, but the coordination of these benefits by one entity will enhance efficiency and improve the quality of care. Further, the State will encourage health plans to use their option to include additional benefits as a way to further improve quality and increase enrollment.

The coordination of services will lead to better health outcomes, greater cost-effectiveness, and care being provided in the most appropriate setting. Currently, there is a potential incentive for either Medicaid or Medicare to reduce expenditures by sending beneficiaries to providers and/or settings that the other is responsible for payment. Medicare generally is responsible for most primary and acute care services while Medicaid is responsible for most long term care services and supports. For example, Medicare could reduce its costs by shifting care to nursing facilities, where Medicaid is typically the payer. Likewise, Medicaid could reduce its costs by shifting care to hospital settings, where Medicare is usually the payer. Unfortunately, this type of incentive structure can increase aggregate costs, create confusion for beneficiaries, and even harm people's health.

By creating a coordinated system of care, cost-shifting will be reduced, because the health plans will be responsible for managing all benefits. Health plans will receive the same reimbursement regardless of the setting where care is provided. Medicare and Medicaid will be responsible for the same per member per month payments regardless of where services are delivered. Health plan performance with respect to quality measures will impact what the health plans are paid, in order to ensure that decisions are based on what is best for the person. In the new system, neither the health plan, nor Medicare, nor Medicaid will benefit financially from shifting care to a setting which is not beneficial to the person.

As one example of how the new system can benefit all parties, consider individuals residing in more restrictive settings than necessary or desired. Some people live in a nursing facility (NF) or an intermediate care facility for the intellectually disabled (ICF/ID) even though they could thrive in a community setting. These individuals can benefit greatly if they transition from institutional care into the community. Benefits for many parties from such a transition would be substantial. The individual could have greater freedom and a higher quality of life due to being in a less restrictive setting. The State could ensure compliance with the Americans with Disabilities Act, as interpreted by the Supreme Court's decision in the *Olmstead* case.[3] The health plan could realize substantial savings, as care in the community is significantly less costly than care in institutions. Medicare and Medicaid would also share in any savings, regardless of which program the benefits would ordinarily have been obtained through.

All individuals with full eligibility for Medicaid and Medicare who live in the State of Idaho will be eligible to participate in the proposed demonstration. This means that participants must be at least 18 years old, because that is the minimum age requirement to be eligible for Medicare. The population is classified in more detail in *Table B*, below. Individuals who are partial dual eligibles (i.e. do not receive Medicaid health care services but do receive assistance from Medicaid in paying Medicare premiums) are NOT eligible for this proposed demonstration.

[3] *Olmstead v. L.C.*, 527 U.S. 581 (1999)

Table B: **Dual Eligible Classifications-March 2012**

	Dual Eligibles	Dual Eligibles Receiving Long Term Support Services (LTSS) in Institutional Settings		Total Dual Eligibles Receiving LTSS in Institutional Settings	Individuals receiving LTSS in Home and Community Based Service Settings	Individuals not Receiving LTSS Services
		ICF/IDs	SNF	ICF/IDs + SNFs		
Total	**17,735**	**194**	**1,364**	**1,558**	**5,779**	**10,398**
Individuals age 65+	**7,201**	**22**	**1,079**	**1,101**	**2,634**	**3,466**
Individuals ages 18-65	**10,534**	**172**	**285**	**457**	**3,145**	**6,932**
Individuals with serious mental illness (SMI)	**2,089**	**11**	**113**	**124**	**713**	**1,252**
Individuals with SMI, age 65+	**299**	**3**	**71**	**74**	**152**	**73**
Individuals with SMI, under age 65	**1,790**	**8**	**42**	**50**	**561**	**1,179**

C. Care Model Overview

i. Description of proposed delivery system/programmatic elements:

- Geographic service area(s):
  Statewide
- Enrollment method(s):
  In 2013, enrollment into the current MMCP will continue to be completed through an entirely voluntary, opt-in process. Before October 2013, beneficiaries will be notified of their mandatory enrollment into a health plan effective January 1, 2014. This notification will also include information regarding how participants may exercise their rights to change to a different plan in any given month. On January 1, 2014, mandatory enrollment will be implemented for the Medicaid component of the plan. Also in 2014, passive enrollment with an opt-out option will be put in place for Medicare benefits. Before 2014 enrollment begins, participants will receive a mailing that

explains the program and informs them of all their available plan enrollment options. The State also intends to use a third-party, independent enrollment broker to facilitate communications and assist participants in selecting the right health plans for their needs. The State, CMS, the health plans, and the enrollment broker will collaborate to ensure that any informational materials presented are clear and consistent.

If a participant does not select a health plan, one will be selected for that individual based on a pre-determined methodology. For the limited number of participants who are already enrolled in a MMCP, but do not select a plan by January 1, 2014, the State intends to explore an enrollment methodology that allows them to remain with their current plan. From the group of all full dual eligibles who do not select a plan, the State intends to enroll as equal a number as possible into each available plan.

- Available medical and supportive service providers:

  Managed care providers will be required to ensure the availability of appropriate service providers who are proficient in meeting the needs of the dual eligible population, in accordance with Medicaid and Medicare requirements. In the State of Idaho, the following resources exist:

  Statewide as of March 2010

  - Hospitals: 51
  - Certified Family Homes: 2,152
  - Skilled Nursing Facilities: 79
  - Residential Care/Assisted Living Facilities: 290
  - Rural Health Clinics At least 46
  - Federally Qualified Health Centers At least 38
  - Tribal Clinics At least 5
  - Medicaid Providers (Excluding Dentists) 3,525
  - Dentists Accepting Medicaid 680
  - Personal Assistance Agencies 259

ii. Proposed benefit design, alignment of Medicare and Medicaid services, and responsibility for managing services.

CMS, the State, and the health plans will agree to a three-way contract. The health plans will receive capitated payments. The health plans will make arrangements to provide for coverage of the full spectrum of medically necessary Medicare and Medicaid services, including Medicaid waiver services (see Table A). A single, cohesive set of benefits will be made available. One benefit card will be used to access services, rather than multiple cards. A single process will be in place to obtain the care that is needed. A single health plan will answer all questions regarding care. A single health plan will handle all initial appeals. Medicare and Medicaid

services, and the associated policies and procedures, will be aligned in one health plan even though the ability to receive those benefits originates in two distinct sources. The participant should not notice practical differences based on whether a service is available through Medicare or Medicaid.

The health plan will provide for service coordination by contracting with a care management team that will implement principles associated with the health home model of care. As described in CMS' State Medicaid Director Letter #10-024 from November 16, 2010[4], the health home model of care requires the following:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The care management team will at a minimum consist of the participant, a care coordinator, and a primary care physician (PCP). The PCP is the anchor of the team, but additional team members/providers will be added as needed in order to effectively coordinate and provide the full range of Medicare and Medicaid services through a multidisciplinary approach. The participant should play as active a role with the team as possible.

The broader team could grow to include a pharmacist, advocate, family member, mental health providers, or HCBS providers. The care management team's health home approach means that it will coordinate care with all providers and facilities, assist with discharge planning, manage care for those with complex medical needs, and facilitate transitions between providers and between institutional and community settings. The team will emphasize preventive care, and it will help ensure that principles of person-centered care and evidence-based practices are followed as a matter of standard practice.

More specifically, the care team must:

1. Work with the participant/family to develop a comprehensive, written plan of care that includes the following, at minimum:
    a. A summary of current health status and health history;
    b. A person-centered approach that includes the participant's goals, status of goals, barriers to goals, and specific recommendations on how to achieve goals;
    c. List of all diagnoses and medications;
    d. List of all health problems and concerns:
        i. A plan to correct or manage each acute and chronic condition, and prevent potential problems that are likely to develop without intervention;

[4] "Health Homes for Enrollees with Chronic Conditions." Centers for Medicare and Medicaid Services. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

ii. Self-management information and training whenever appropriate;
   e. List of acute and chronic medical, behavioral health, long-term care, and social service needs, and supports/services already in place;
   f. Treatment goals that are reviewed and updated with each relevant visit;
   g. Participant's role in increasing wellness, including practical ways the participant can improve health and quality of life; and
   h. Summary of the role of each member on the care team, and how the members of the care team will interact and collaborate through the course of the year.
2. Update the care plan on an ongoing basis as appointments occur, tests are completed, medications change, transitions are made; goals are added or completed, etc.
3. Provide comprehensive care coordination and management:
   a. Communicate with all providers on the care team about any health issues that could affect their care;
   b. Communicate with all facilities where the participant may live or receive care about any health issues that could affect their care;
   c. Make referrals to appropriate providers as needed;
   d. Collaborate with facilities on discharge planning to ensure the appropriate safeguards are in place after leaving the facility;
   e. Communicate with other providers regarding results of appointments;
   f. Ensure that participants are aware of their roles and the roles of various providers; and
   g. Ensure that all providers and facilities are aware of and working towards the same goals.
4. Offer same-day appointments.
5. Emphasize and implement principles of evidence-based practices, and offer/encourage preventive care.
6. Connect the participant with community-based resources when appropriate.
7. Attempt to schedule a minimum of one appointment with the PCP annually, even if there are no immediate health concerns.
8. Provide timely clinical advice by phone during office hours.
9. Offer communication options by phone and email.
10. Counsel at least 50 percent of patients/families to adopt specific, healthy behaviors.
11. Provide educational resources for at least 50 percent of patients/families to assist in self-management.
12. Promptly notify the health plan if an individual in need of services stops attending appointments and receiving services (at which point the health plan must contact the individual and take steps needed to re-connect the person with necessary services).

iii. Service Availability

From the participant perspective, no services will be modified, added, or removed. What will change is that all Medicaid and Medicare services will be obtained and coordinated through one health plan. Idaho Medicaid has a robust array of benefits available to dual eligible participants, and all current benefits will continue to be available through the new health plans. Depending on which eligibility criteria are met, participants may currently be enrolled in the Medicaid Basic Plan, Enhanced Plan, Home and Community Based (HCBS) Waivers, or MMCP. In 2014, the

full spectrum of Medicaid benefits in these programs will be available through the new coordinated health plans. (Refer to Table A for a summary of Medicaid services the health plans will be required to offer.) For some of these services available through Medicaid, Medicare is currently the primary payer for dual eligibles. However, when the health plan covers all services in 2014, it will in effect become the sole payer for all services, regardless of whether Medicare or Medicaid would have ordinarily been responsible for payment. The State will encourage health plans to offer additional benefits not covered in the state plan as a means of enhancing quality and competing for higher levels of enrollment. However, federal regulations prohibit the costs for these additional services from being built into the capitation rate paid to the health plans.[5]

iv. Evidence-based practices as part of the care model.

The State requires health plans to adopt practice standards which are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. The State also requires plans to review provider practices to ensure compliance with these standards. The standards should be developed in consultation with contracting health care professionals, they should be consistent with standards set forth by leading academic and national clinical organizations, and they should consider the needs of the enrollees. They should be reviewed and updated as appropriate from time to time. The standards should be disseminated to all affected providers, and upon request, to enrollees and potential enrollees. The health plans will take all steps necessary to ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the practice standards apply are consistent with the standards.

v. How the proposed model fits with: (a) current Medicaid waivers and State plan services; (b) existing managed long-term care program; (c) existing specialty behavioral health plan; (d) integrated programs via Medicare Advantage Special Need Plan (SNPs); and (e) other CMS payment/delivery initiatives or demonstrations

a. *Current Medicaid waivers and/or State plan services available to this population:*

Idaho's basic plan covers a package of medical services designed to meet the health needs of low-income children and working-age adults. This plan provides health, prevention, and wellness benefits for children and adults who do not have special health needs. Most Medicaid participants are in this benefit plan.

Idaho's enhanced benchmark plan provides all the basic plan services and additional services, such as developmental disability services, long term care services, and enhanced mental health services, for those individuals who qualify due to disabilities or special health needs.

Two home and community based waivers, the Aged and Disabled waiver and the Developmentally Disabled waiver, offer services in addition to the Basic Plan services and

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *U.S. Code of Federal Regulations*, 42, sec. 438.6 (2002).

Enhanced Plan services that waiver participants may also receive. These include a variety of home and community-based services which help people to live in the community and avoid institutionalization.

The proposed model will not reduce any current State plan services or Medicaid waiver services for eligible individuals. Rather, it will provide all covered services for dual eligible individuals in a seamless manner. This includes either Aged and Disabled waiver services or Developmentally Disabled waiver services for qualifying individuals. Everyone who qualifies for waiver services will receive waiver benefits in the coordinated plan because Idaho does not have a waiver waiting list. All the services will be provided under the umbrella of the managed care plan, so that the care can be coordinated by a single entity. All Medicaid (and Medicare) services a person qualifies for will, in essence, be integrated into the coordinated care plan for dual eligibles.

b. *Existing managed long-term care programs:*

As mentioned earlier, Idaho currently offers a Medicare-Medicaid Coordinated Plan (MMCP), which coordinates all Medicare services and many Medicaid services. The plan has shown promising results, but enrollment levels remain low due to the opt-in enrollment structure. Although the MMCP covers many Medicaid services detailed in Idaho Administrative Procedure (IDAPA) §16.03.17.301, it does not currently cover a significant number of Medicaid services, including nursing facility services or HCBS waiver services. Those benefits excluded from the MMCP are now obtained through the Medicaid fee-for-service structure.

The proposed model builds upon many of the same principles used in the existing MMCP. However, the new model will be comprehensive, and it will include long term care services. Specifically, new services required in the health plans in 2014 will include nursing facility services, personal care services, mental health services, waiver services, medical transportation, and developmental disability services. Because the current MMCP plan has had relatively low participation rates (only 604 of 17,735 dual eligibles were enrolled as of June, 2011), additional outreach and educational efforts may be conducted to increase participation rates in the MMCP in 2013. In 2014, Idaho Medicaid will enroll all full dual eligibles into the health plans in order to ensure well-coordinated, high-quality care for Idaho's dual eligible individuals.

c. *Existing specialty behavioral health plan:*

In 2013, Medicaid participants will receive mental health benefits through a new, Statewide managed care plan. Medicaid issued a Request for Information (RFI) for this mental health managed care program, and responses from local and national managed care companies have been reviewed. A Request for Proposal is being developed to take the next steps in the contracting process. The mental health managed care program is expected to be in place by 2013, and all Medicaid participants, including dual eligibles, will receive their mental health benefits through the single mental health managed care plan until the December 31, 2013.

Full dual eligibles who are enrolled in the mental health managed care program in 2013 will be transitioned out of that program and into a health plan for duals effective January 1, 2014. All health plans for duals will be required to offer the same mental health services provided in the mental health managed care program for all qualifying dual eligible participants. Full dual eligibles will receive all benefits, including mental health benefits, through the integrated health plans specifically created for duals. Health plans will be free to provide these benefits by contracting with the same managed care entity that provides mental health benefits for non-dual Medicaid participants, or they may provide for the same set of benefits through other means.

d. *Integrated programs via Medicare Advantage Special Need Plan (SNP):*

The existing Idaho Medicare-Medicaid Coordinated Plan is a Medicare Advantage Special Needs Plan (SNP). The details of this plan are described in the State's administrative code, at IDAPA 16.03.17. The MMCP plan will be replaced by this new program to integrate care for all full dual eligibles in 2014. The current MMCP will not continue to exist after the new program has been implemented on January 1, 2014. Multiple health plans can participate in the new initiative, as the State does not currently expect a need to limit the number of health plans. An absolute minimum of two health plans will participate. The structure of the new plans will share much in common with the existing MMCP, although nursing facility services, personal care services, psychosocial rehabilitation, waiver services, medical transportation, and developmental disability services will be added. This represents a substantial expansion in services being coordinated by one entity, and it should result in improved care.

e. *Other CMS payment/delivery initiatives or demonstrations:*

As mentioned earlier, all full dual eligibles will be linked to a primary care provider who will follow a health home approach. Idaho is also working to create a Medicaid State plan option to offer health homes for individuals with the following conditions:

1) A serious, persistent mental illness, or
2) Diabetes and an additional condition, or
3) Asthma and an additional condition.

The exact implementation date is uncertain, but is believed to be in the second half of calendar year 2012. The new coordinated plans for dual eligibles will need to contract with the health homes to ensure that those benefits will be made available to all qualifying dual eligible individuals, as they will become required Medicaid State plan benefits.

To qualify as a health home, specific requirements must be met. Although the details of the health home program have not yet been finalized, health homes are primary care practices which will provide comprehensive care management for the whole person. The health home model will provide care for an individual's physical condition, and it will also provide links to long-term community care services and supports, social services, and family services. The health home program and the coordinated care program should fit together well, because both share the provision of seamless, efficient care as an important goal. Further, the plans are required to

contract with PCP's and care coordinators who will use health home principles for all participating dual eligibles who do not formally qualify for health home services under the State plan. The health home will receive Fee for Service payments from the health plan for services rendered. The health home will also receive a per member per month payment for the coordinating and managing the Medicaid services of individuals who qualify for health homes.

D. Stakeholder Engagement and Beneficiary Protections

i. Engagement of internal and external stakeholders

Implementation of this proposal will rely on effective partnerships with participants, families, advocates, providers, health plans, etc. Success will largely be contingent upon engagement and the capacity of health care and service providers that support and care for Medicare-Medicaid enrollees in their communities. Stakeholder input has been welcomed and encouraged throughout the development process. Idaho Medicaid recognizes that developing a managed care program for dual eligible participants is a collaborative, statewide effort involving participants, families, Medicaid staff, providers, health plans, community partners, and agencies. Medicaid continues to seek input and feedback from all interested parties. A summary of the history and status of stakeholder involvement follows:

A website is available to facilitate communication with stakeholders at *http://www.MedicaidLTCManagedCare.dhw.idaho.gov* . Website features include a summary of the history and status of the initiative, a survey through which suggestions can be offered, a feedback form which takes suggestions and questions, a brief of the proposal, links to panelist presentations at a Statewide stakeholder videoconference, information regarding upcoming events, and a number of helpful links.

In addition to the website, other efforts have been and will continue to be made to work with broad groups of stakeholders. For instance, a Statewide videoconference was held with consumers, advocates, and providers on October 26, 2011. More than 50 people participated in the meeting, which was held at the Boise Medicaid State office and available by videoconference at six other sites throughout the State. Idaho Medicaid Long Term Care Bureau Chief Natalie Peterson provided background and information for the dual eligible managed care initiative. Following her presentation, a panel of six stakeholders presented their ideas and priorities for the design of a managed care system for dual eligible participants. Their PowerPoint presentations are available by clicking their names at *http://www.MedicaidLTCManagedCare.dhw.idaho.gov*. Many expressed hope in the promise of a well-designed program, while recognizing some potential challenges.

Another Statewide videoconference was held to discuss this proposal on April 17, 2012. The purpose was to gather feedback and suggestions, and make any needed changes before submitting the proposal to CMS. A webinar was held on May 25, 2012, to allow stakeholders a chance to review the State's changes in response to feedback received in written narrative form and in survey responses. Further, stakeholders continue to have an opportunity to discuss issues for dual eligible individuals through the quarterly Personal Assistance Oversight (PAO)

committee meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing Facility Prospective Payment System meetings.

A number of meetings have also been held with the potential health plans. An initial meeting was held on September 26, 2011, with five interested plans in attendance (Pacific Source, United Healthcare, Blue Cross of Idaho, Regence Blue Shield, and Sterling Plans). An overview of CMS's guidance on opportunities to align financing between Medicare and Medicaid to support improvements in quality and cost of care was given. This was followed by a discussion of the current MMCP, and feedback was provided on strengths and weaknesses of that program from the perspective of the health plans and Medicaid. There was a discussion that focused on barriers to enrollment in that program, strengths of the model and opportunities for improvement. Medicaid solicited and received input regarding the interest in offering a fully integrated model and the readiness of the health plans to offer such a model. Concerns, hopes and suggestions on how to make such a model a success were discussed. Plans expressed excitement about the opportunity to coordinate care. The importance of having one set of processes was mentioned, so that beneficiaries will not have to go to several places to obtain the information they need. One health plan indicated that it had completed a readiness review and had the core elements needed for the program in place already. There was recognition that the target implementation date of January 1, 2013 was an aggressive timeline. This feedback, along with similar feedback from other stakeholders, was significant in shaping the decision to move the target implementation date to January 1, 2014. Please refer to Attachment 1 for the meeting minutes from the September 26, 2011 meeting. Monthly meetings with health plans began on December 2, 2011 and continued through May10, 2012. Idaho Medicaid also sent a tribal notice letter regarding the proposed program on April 3, 2012.

Idaho Medicaid has considered and incorporated feedback regarding the importance of self-direction and payment structures that encourage the proper utilization of care. A self-direction option must be offered by all participating health plans. Participants must be permitted to choose and change their direct care staff. Further, health plans reimbursement will be tied to quality measures to ensure that appropriate care is provided. Feedback will continue to be encouraged and considered throughout the demonstration. Additional comments have been offered regarding challenges of covering services for the developmentally disabled population in 2014. For this reason, the State may consider a phased-in approach to including services for people who have developmental disabilities in the demonstration.

A number of other managed care meetings have been held throughout the development of this proposal. Oregon and Utah presented their managed care experience to the Idaho Legislature on November 18, 2011, and several Medicaid representatives attended. A public forum on Medicaid managed care program for comprehensive medical services was held on December 13, 2011, and a hospital panel, a physician panel, and a community health center panel presented their recommendations. Managed care presentations were given to Idaho Senate committee members on February 16, 2012 and to Idaho House committee members February 24th. The Nursing Home Prospective Payment System meeting with skilled nursing and intermediate care facility providers on February 23, 2012 also included a discussion regarding managed care for dual eligibles.

Input from stakeholders will continue to be encouraged and facilitated as the initiative moves forward. Stakeholders will continue to have an opportunity to discuss issues related to the demonstration through the quarterly Personal Assistance Oversight Committee (PAO) meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing Facility Prospective Payment System meetings. The demonstration to integrate care for dual eligibles is a standing agenda item at the PAO and MCAC meetings. Additionally, stakeholders will continue to be able to submit feedback by email to LTCmanagedcare@dhw.idaho.gov. Further, the State will require health plans to operate an advisory committee which will meet in person a minimum of two times a year. The committee will be composed of providers, participants, and participants' representatives.

ii. Description of beneficiary protections.

The beneficiary will be afforded numerous protections. The following processes and protections will be in place for the beneficiaries:

A. The plan must make a comprehensive enrollee handbook available to prospective enrollees upon request and actual enrollees upon enrollment. It shall be written in plain language and it shall be available in formats that are accessible and understandable for people with disabilities or limited English proficiency.
B. The beneficiary may choose which participating health plan to join.
C. The beneficiary may choose appropriate providers from within the plan's network.
D. At least two health plans will be available to choose from.
E. A beneficiary who is dissatisfied with the current health plan may disenroll from that plan and enroll in a new health plan, effective the first of any month, so long as Medicaid is notified and the change is requested fifteen (15) days in advance.
F. Beneficiaries must have an option to self-direct their care; they must be permitted to choose and change their direct care staff.
G. Beneficiaries may opt out of the plan for their Medicare benefits.
D. Contractor shall maintain a network of appropriate providers supported by written agreements. The beneficiary may choose amongst the available providers within the plan's network.
E. Contractor shall maintain a network of appropriate providers sufficient to provide adequate access to all services covered under the contract, and Contractor shall comply with federal requirements in 42 CFR §422.112 regarding access to services.
    1. Medical and pharmacy network adequacy requirements will be based on Medicare requirements.
    2. The State's network adequacy requirements will be used for Medicaid-only services.
    3. For services covered by Medicare and Medicaid, CMS and the State will collaborate to develop network adequacy standards.
F. Contractor must work towards being certified by the National Committee for Quality Assurance (NCQA).

G. Contractor must ensure all beneficiary protections required in federal and State statutes and regulations for Medicare and Medicaid beneficiaries.

H. Contractor shall safeguard the privacy of enrollee health records and provide enrollees access to the records upon request.

I. Customer service representatives (CSRs) must be available for a minimum of forty hours per week during standard business hours. CSRs must be sensitive to the language and culture of the participant, and they must be able to answer enrollee questions and respond to complaints and concerns appropriately.

I. In establishing and maintaining its network of providers, Contractor must consider the following:

1. The anticipated Medicaid enrollment;
2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented among Contractor's enrollees;
3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
4. The numbers of network providers who are not accepting new Medicaid patients; and
5. The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
6. Continuity of care for participants.

Contractor agrees to facilitate reasonable access to medical care for enrollees. The following time frames should be adhered to, to provide reasonable access to care:

Preventive care appointments for wellness exams and immunizations	42 calendar days
Routine assessment appointment for follow-up evaluations of stable or chronic conditions	30 calendar days
Non-urgent medical care appointments for treatment of stable conditions	7 calendar days
Urgent care appointments for treatment of unforeseen illnesses or injuries requiring immediate attention	24 hours
Waiting time in provider's office for scheduled appointment	Less than 45 minutes
There is a 24-hour physician coverage, provided by the physician or with an on-call arrangement	Routine referral to the local emergency room is not acceptable
24 hour per day, 7 day per week access	Must be available at all times

to a phone line staffed by a nurse	

Nondiscrimination and Civil Rights: The Contractors agree to comply with the following acts:

1. Title VI of Civil Rights Act of 1964 (Codified at 42 USC 2000 et. Seq.), 45 CFR Part 80
2. Title IX of the Education Amendments of 1972 (regarding education programs and activities);
3. Age Discrimination Act of 1975
4. Section V of the Rehabilitation Act of 1973
5. Title II of the Americans with Disabilities Act of 1990
6. Health Insurance Portability and Accountability Act of 1996 (codified at 42 USC §1320d et seq.)
7. All regulations and Administrative Rules established pursuant to the foregoing laws, and
8. All other applicable requirements of federal and State civil rights and nondiscrimination statutes, rules and regulations.

Hospital Patient Rights: To the extent applicable, the Contractor shall comply with, and shall require subcontractors to comply with, the Patient Rights Condition of Participation (COP) that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR §482. For purposes of this contract, hospitals include short-term, psychiatric rehabilitation, long-term, and children's hospitals.

Nursing Facility/Long Term Care Rights: To the extent applicable, the Contractor shall comply with, and shall require subcontractors to comply with, all long term care facility requirements in 42 CFR §483.

The plan will also comply with any other applicable statute or rule related to participant rights.

The outline of a beneficiary grievance and appeal process is included in Attachment 11. The state will collaborate with CMS to develop the final, unified appeals system, under which all appeals will initially be made to the health plan. Health plan decisions unfavorable to the participants will be subject to an external review process.

iii. Plans for Additional Stakeholder Collaboration, and Communications with Beneficiaries.

Steps will continue to be taken to gather and incorporate stakeholder input. Monthly meetings with the health plans began December 2, 2011, and continued through May 10th, 2012. Stakeholders also have an ongoing opportunity to discuss issues related to the demonstration through the quarterly Personal Assistance Oversight Committee (PAO) meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing Facility Prospective Payment System meetings. The initiative to integrate care for dual eligibles is a standing agenda item at the PAO and MCAC meetings. When the demonstration proposal is finalized in April, an announcement will be made and the proposal will be posted on

http://www.MedicaidLTCManagedCare.dhw.idaho.gov. A statewide stakeholder videoconference was held on April 17th to discuss the proposal. A webinar was held on May 25, 2012, in order to discuss feedback and the State's response to feedback. A survey and a feedback form are also available on the website.

The Department will continue to inform all parties as significant developments occur through *http://www.MedicaidLTCManagedCare.dhw.idaho.gov*. Participants will be notified of any significant changes by mail. Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs), and the 2-1-1 Idaho CareLine will also be utilized as communication partners. Additional communications by other appropriate methods will be made whenever needed. The Department will make various resources available in order to provide interpreter and translation services to participants who are Limited English Proficient (LEP). The Department will provide access to over-the-phone interpretation, on-call interpretation, employee interpretation, oral translation, and translation services. Additionally, the Department will provide reasonable accommodation to an applicant/participant with a qualified disability, which might include translating a document into Braille or providing it in large-print, or on tape. The Department's Civil Rights Manager is available to answer questions about providing such assistance.

E. Financing and Payment

i. Payment reforms and financial alignment model.

The capitation financing model will be used in this initiative. Participating plans will receive a per member per month payment (PMPM) for each enrollee in exchange for delivering the integrated set of Medicare and Medicaid benefits. The exact amount of that payment will be based on an actuarial analysis of historical costs and anticipated savings resulting from the integration of services and improved care management. The contracting health plans will assume full risk for all required services for enrollees. The State and CMS will review health plan performance with respect to quality measures, and payments will be adjusted based on the results. Any savings from the program will be shared by Medicare and Medicaid in proportion to contributions made by the two programs. It is important and helpful from the State's perspective that any savings will be shared in this initiative, because most savings in integrated Medicare-Medicaid health plans are expected to be seen from reduced primary and acute costs, which are covered primarily by Medicare.[6]

ii. Payments to providers.

Critical steps in the rate development process include the following:

- The State provides summaries of monthly eligibility and claim experience for each MMCP enrollee on a PMPM basis to facilitate the analysis for the actuarial rate certification. The summary will be based on the claims detail for the 36-month period of

[6] "Financial Alignment Models for Medicare-Medicaid Enrollees: Considerations for Reimbursement." Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/Payment_and_Reimbursement_FINAL.pdf.

7/1/2008 – 6/30/2011. The detailed claims data will be summarized by service category and membership months for each of the counties and populations of dual and non-dual beneficiaries. The data is then mapped into rate categories.

- Base experience will include all services to be covered by the health plan.
- The cost projections include adjustments for trend, health care management, selection and health plan administrative costs.

The Medicaid capitation payment does not include physician incentive payments. The Contractor must comply with all requirements and limitations set forth in 42 CFR § 422.208 and 42 CFR § 422.210. The health plan must submit a report to the Department quarterly which summarizes all incentive payments made. The report shall include what the incentive payment was for and the amount of the incentive payment. The health plan shall provide to enrollees, upon request, physician incentive payment program information. The health plan will pay providers no less than the Medicaid rate for services rendered at the time of service delivery. The health plan will pay the provider promptly and in a timeframe comparable to the Medicaid payment timeframe when a complete and accurate claim is submitted.

F. Expected Outcomes

i. Ability of the State to monitor, collect and track data on key metrics related to quality and cost outcomes

The State currently conducts oversight and monitors the Medicare-Medicaid Coordinated Plan by reviewing the following reports quarterly:

a. Medicare Cost and Utilization
b. Member Level Risk Categories
c. Medicare Part D Reporting
d. Disease Management Report
e. Network provider geographic distribution report

The State will continue to conduct reviews of such reports under the new program. The State will require the health plans to monitor, collect, and track data on key cost and quality metrics, including beneficiary experience, access to and quality of all services, utilization, etc. The State will conduct surveys and pull claims data to determine financial trends. Specific potential metrics include provider/beneficiary ratios, decreases in hospitalizations, wait times for appointments, percent of individuals receiving yearly visits to their primary care physicians, percent of individuals receiving preventive care, etc. A detailed set of metrics will be developed and included in the three-way contracts. The State has a Medicaid Management Information System (MMIS) to access Medicaid claims data. A joint selection process will be used with CMS to determine which quality measures will be considered for purposes of payments to health plans.

ii. Potential improvement targets for quality measures

The State will work with stakeholders to develop specific numerical targets and measures to ensure that appropriate standards are in place to ensure a high quality of care. Quality measures will relate to system performance, clinical performance, and administrative performance. Potential quality measures in each area include but are not limited to the following:

1. System Performance
    - The size of the network of appropriate providers
    - The number of network providers accepting new Medicaid patients
    - The number of enrolled beneficiaries
    - The provider/beneficiary ratio by specialty
    - Wait times for appointments
    - Utilization rates

2. Clinical Performance
    - Number of hospitalizations
    - Number of re-hospitalizations
    - Number of skilled nursing facility admissions
    - Preventive care (annual check-ups, disease screenings, etc.)
    - Emergency room visits

3. Administrative Performance
    - Satisfaction surveys
    - Timely resolution of complaints/grievances
    - Timely claims payments
    - Service denials

iii. Expected impact on Medicare and Medicaid costs

Although the exact savings are uncertain, the potential is significant. According to the an August 2011 study from Special Needs Consulting Services (SNCS), Idaho can expect to save $8,426,110 for each 1% in savings on the current money paid for dual eligible individuals' services through the fee-for-service system.[7] Further, the SCNS study references a 2008 Lewin Group report which indicates that an optimal coordinated care program could save an average of 3.7% on dual eligibles' costs over a ten-year timeframe.[8] The same report estimated Year 1 savings to be 2.7%. Idaho Medicaid and CMS will collaborate on developing more precise estimates of individual and combined expenditures and savings for Medicaid and Medicare in the three years of the demonstration.

G. Infrastructure and Implementation

[7] Special Needs Consulting Services. "Achieving Optimal Care Coordination for Medicaid/Medicare Dual Eligibles." (August 2011).

[8] The Lewin Group. "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities" (November 2008).

i. Description of State infrastructure/capacity to implement and oversee the demonstration.

Idaho is prepared to devote the necessary staff to ensure the initiative is successful. The following is a list of staff members who will be involved in the project:

Executive Sponsor:	Leslie Clement
Business Sponsor:	Paul Leary
Business Sponsor/Project Lead:	Natalie Peterson
Project Manager:	Michele Turbert
Project Team:	Lisa Hettinger
	Robert Kellerman
	Sheila Pugatch
	Mark Wasserman
	Cynthia York

Administrative Support:	Marcie Young
Communications Specialist:	Tom Shanahan

Idaho currently has significant ability to access Medicare cost reports through a Certified Public Accounting (CPA) firm, Meyers and Stauffer. Access varies depending on the type of provider, as described below:

Hospitals
One of Meyers and Stauffer's contractors receives ECR/MCR cost reports that are housed on their server. The State does not have direct access to the contractor's server so data must be requested separately. The cost reports aren't requested by the contractor until after the Medicare audit is complete so the data they currently have is 2-3 years old. However, the contractor is working on a method to download HCRIS electronic data from the CMS website to have access to more current cost reporting data.

Nursing Facilities
One of Meyers and Stauffer's contractors receives ECR/MCR cost reports that are housed on their server. The State does not have direct access to the contractor's server so data must be requested separately.

Home Health Agencies (HHAs)
Meyers and Stauffer only receives paper cost reports and has no access to electronic data.

FQHCs
These cost reports are only received on an as-needed basis for a few providers. For this provider type, the data is old and only for a few providers.

Idaho Medicaid will provide CMS with any needed data upon request, including but not limited to expenditure and encounter data. Idaho Medicaid also intends to use the process CMS has made available in order to access timely Medicare Parts A and B claims data and D event data, and Medicare Parts A, B, C, and D eligibility and enrollment data.[9]

ii. Implementation strategy / anticipated timeline

Idaho Medicaid has developed a project plan and timeline that list the steps that must be taken to achieve implementation. Please refer to the timeline in Section K for details.

H. Feasibility and Sustainability

i. Potential barriers/challenges.

Statutory and regulatory changes will be required to implement the proposal. These changes should not be problematic, as the program fits within the legislative direction of House Bill 260. Implementation is also dependent on finding an absolute minimum of two health plans willing and capable of participation. To help with this, monthly meetings with health plans began on December 2, 2011, and communications will be ongoing and encouraged. The State will collaborate with the health plans and all stakeholders in efforts to create the most effective program possible.

Further, the health plans will need to be able to contract with sufficient numbers of providers in all service areas. As demonstrated in Section C(i) of this proposal, however, there are large numbers of providers and a wide variety of facilities and provider types available to provide good access to care for the dual eligible population.

ii. Remaining statutory and/or regulatory changes needed.

Significant regulatory and statutory changes are needed in order to implement this initiative. For instance, IDAPA §16.03.17, the section containing the current MMCP §1937 benefits plan, will need to be replaced by 2014. Minor revisions will also be needed to IDAPA §16.03.09 and IDAPA §16.03.10. Further, a statutory revision is needed in Idaho Code §56-254, also due to the MMCP §1937 benefits plan being replaced.

iii. New State funding commitments or contracting processes needed.

A funding commitment will be needed to implement required systems changes. Contracts will need to be agreed to by the health plans, CMS, and Idaho Medicaid before implementing enrollment into the coordinated health plans in 2014. The procurement process will need to be followed.

iv. Scalability and replicability in other settings/States.

[9] "Medicare Data for Dual Eligibles for States." Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-medicaid-coordination/06_MedicareDataforStates.asp

The managed care model should be replicable in other States and settings. In fact, managed care programs have already been successful in a number of settings and States. As of 2009, CMS statistics show that more than 70% of Medicaid enrollees were members of managed care plans.[10] Idaho is a large State that is sparsely populated. If the model proves successful here, it should also prove successful if replicated in states with more managed care organizations and providers already in place. This model should help other large, rural states address the challenges created by such conditions. If managed care is successful with the dual eligible population in Idaho, the State will consider bringing additional populations within the State into managed care systems.

v. Letters of support

Please refer to attachments at end of document for letters of support and as well as text from relevant portion of Idaho House Bill 260.

I. Additional Documentation

Additional documentation will be made available as various steps in the process are completed. Some of the additional documentation which will be completed includes:

1) State Plan Amendment to §3.1-C of the Medicaid State plan
2) Statutory revision to Idaho Code §56-254
3) Regulatory revision to replace IDAPA §16.03.17
4) 1915(b) waiver application
5) Amendments to Idaho's 1915(c) waivers (Aged and Disabled waiver, and Developmentally Disabled waiver)

J. Interaction with Other HHS/CMS Initiatives

Idaho intends to use the demonstration for dual eligibles as an additional way of identifying individuals who would be appropriate for the Idaho Home Choice - Money Follows the Person program, which allows individuals to move from institutional settings into the community. Within one year from the time of an individual's enrollment, the health plan will evaluate that person's suitability for the program, based on the following requirements:

a. A participant must have been in a Nursing Facility, Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID), or an Institution for Mental Disease (IMD) for a minimum of 90 days (excluding any Medicare Part A days);
b. A participant must wish to move out of the institution and into a community setting; and

[10] "Medicaid Managed Care Enrollment as of July 1, 2010." Centers for Medicare and Medicaid Services. http://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2010July1.pdf.

c. A participant must be Medicaid-eligible at the time of discharge and a resident of Idaho (these requirements should always be met if an individual participates in the coordinated plan for dual eligibles).

After evaluating the factors listed above, if an individual appears to be a candidate for the program, the health plan will make a referral to Tammy Ray at RayT@dhw.idaho.gov, who would coordinate the transition from that point onward.

This demonstration also fits well with CMS' *Partnership for Patients* project, which seeks to reduce all hospital readmissions by 20% between 2010 and 2013. A reduction in hospital readmissions of dual eligibles is one of the goals of this project, and health plans will track data on this quality measure. Many hospital readmissions are caused by inadequate transitions from one care setting to another. The dual eligibles' primary care teams will take an active role in planning a thoughtful, effective transition, and this will help to minimize the risk of a readmission.

For similar reasons, CMS' *Reducing Avoidable Hospitalizations Among Nursing Home Residents* initiative also fits well with this demonstration. CMS research has indicated that 45% of hospital admissions for those receiving Medicaid nursing facility services are preventable.[11] Principles being implemented in this proposal, such as care coordination, transition planning, preventive care and evidence-based practices are principles that should help to reduce avoidable hospitalizations in the nursing home setting.

Last, this initiative should help to further the goals of the *Million Hearts* initiative. While the care integration effort is not directly connected to *Million Hearts*, better care coordination and a greater emphasis on prevention should help reduce heart attacks and strokes. This may occur as a result of aspirin therapy, lifestyle changes, or in some cases through medications for blood pressure or cholesterol. From a broader perspective, better monitoring of a wide variety of risk factors for many health problems should be in place with the participation of the managed care health plans in 2014. This should help to achieve the ultimate goal of this project: better health for Idaho's citizens who are enrolled in Medicare and Medicaid.

K. Workplan/Timeline

Planned Completion Date/Status	Key Activities/Milestones	Responsible Party/Parties	Status
September 26, 2011	Stakeholder meeting with health plans. Five plans in attendance (United Health Care, Blue Cross of Idaho, Regence Blue Shield, Pacific Source, and Sterling).	Health Plans/State	Completed

[11] "Reducing Avoidable Hospitalizations Among Nursing Home Residents." Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html

October 1, 2011	Submit letter of intent to CMS by October 1st, 2011; submitted on September 25th, 2011.	State	Completed
October 6, 2011	Draft of Milliman Actuary Report, October 6, 2011.	State's accounting firm	Completed
October 26, 2011	Consumers, advocates and provider meeting.	State	Completed
November 1, 2011	CMS/Idaho technical assistance call.	CMS/State	Completed
November 18, 2011	Managed care organizations from Utah and Oregon will appear before the legislature to discuss managed care issues.	State	Completed
November 21, 2011	Complete first draft and send to team for review.	State	Completed
November 28, 2011	Team comments on first draft sent (fiscal details to be completed later).	State	Completed
November 30, 2011	Incorporate team comments.	State	Completed
December 2, 2011	Meeting with health plans.	Health Plans /State	Completed
December 9 2011	Comments on draft from sponsors.	State	Complete
December 13, 2011	Meeting with physician groups, hospitals, and safety net providers regarding managed care programs.	State	Complete
December 16, 2011	Modify first draft of proposal based on comments.	State	Complete
January 4, 2012	Discuss initiative at Medical Care Advisory Committee (MCAC) meeting.	State	Complete
January 6, 2012	Meeting with health plan.	Health Plans /State	Complete
February 9, 2012	Meeting with health plan.	Health Plans /State	Complete
March 2, 2012	Meeting with health plans.	Health Plans / State	Complete
April 2, 2012	Submission of draft to project team.	State	Complete
April 3, 2012	Tribal notification letter sent	State	Complete
April 5, 2012	Project team reviews draft and submits suggestions.	State	Complete

April 6, 2012	Incorporate project team comments into draft, and submit to project sponsors for review.	State	Complete
April 13, 2012	Sponsors review and submit revisions to draft.	State	Complete
April 13, 2012	Draft posted to website for public comment for 30 days.	State	Complete
April 17, 2012	Statewide videoconference to discuss draft of proposal.	All stakeholders and State	Complete
May 10, 2012	Meeting with health plans.	Health Plans/State	Complete
Late May 2012	Incorporate feedback into proposal, and obtain sponsor final approval.	State	Complete
May 25, 2012	Statewide webinar to review changes to proposal with all stakeholders	All stakeholders and State	Complete
May 29, 2012	Submit proposal to CMS.	State	Incomplete
June 2012 – November 2012	Research Request for Proposal (RFP) process in collaboration with CMS technical assistance	State	Incomplete
July 2012	Insert fiscal projections after actuarial report completed.	State	In process
November 2012	Interested plans must submit an electronic Notice of Intent to Apply to CMS.	Health Plans	Incomplete
December 2012-February 2013	State/CMS jointly develop RFP	State/CMS	Incomplete
January 2, 2013	Initiate rulemaking process through Idaho's Administrative Procedure Section (APS).	State	Incomplete
March 2013	Release of Health Plan Management System (HPMS) Part D formulary submission module for CY 2013.	Health Plans	Incomplete
March 2013 to June 2013	Procurement documents are released publicly and interested plans submit their bids. Selection panels comprised of CMS and State officials review and select Participating Plans.	State/CMS/Health Plans	Incomplete
April 2013	CMS User ID connectivity form submissions must be received to ensure user access to the CMS HPMS for purposes of submission of formulary and plan benefit package information.	Health Plans	Incomplete

April 2013	Part D formulary submissions due to CMS for interested organizations that are submitting a new formulary (e.g., those that have not submitted a formulary for CY 2013 for non-demonstration plans).	Health Plans	Incomplete
May 2013	Medication Therapy Management Program submission deadline.	Health Plans	Incomplete
May 2013	Part D formulary submissions due to CMS for interested organizations that have already submitted a non-demonstration plan formulary for CY 2013 and intend to utilize that previously submitted formulary for their demonstration plans.	Health Plans	Incomplete
June 2013	Submission of proposed benefit packages to CMS.	Health Plans	Incomplete
June 2013	Deadline for submitting Supplemental Formulary files, Free First Fill file, Partial Gap Coverage file, Excluded Drug File, Over-the-Counter Drug File, and Home Infusion File through HPMS.	Health Plans	Incomplete
July 2013 to September 2013	• Readiness review for participating plans • Contract negotiations with participating plans	Health Plans /CMS/State	Incomplete
July 2013	Begin work on waiver amendments and 1915(b) waiver application and 1915(c) waiver amendment to allow for dual eligible individuals to receive all eligible benefits.	State	Incomplete
July 2013	Demonstration plan selection completed.	CMS/State	Incomplete
Summer 2013 to Fall 2013	Collaborate with CMS on Memorandum of Understanding (MOU). CMS and State sign MOU.	CMS/State	Incomplete
September 2013 at latest, but start once proposal approved	• State Plan Amendment work initiated (if needed) •	State	Incomplete
September 2013	1915(b) Waiver application, and waiver amendments must be submitted at least 90 days in advance of 1/1/14.	State	Incomplete
September 2013	Business requirements documented.	State	Incomplete
September 2013	Sign three-way contracts.	Health Plans /CMS/State	Incomplete

September 2013	• Legal notice of SPA • Submit SPA to CMS	State	Incomplete
October 2013	For selected plans receiving passive enrollments of Medicare-Medicaid enrollees, notification of such enrollment and information about opt-out procedures must be sent to affected beneficiaries. Marketing period begins.	Health Plans	Incomplete
October 2013	• System requirements and cost estimates • Secure funding via administration	State	Incomplete
October 2013 to December 2013	• System changes made • Implementation readiness review	State for system changes, CMS & State for readiness review	Incomplete
October 2013 to December 2013	Medicare Advantage and Part D Annual Coordinated Election Period.	Health Plans /CMS/ Beneficiaries	Incomplete
November 2013	Public notice to participants of SPA/program changes.	State	Incomplete
January 2014	• Enrollment effective date • Implementation work begins • Beneficiary notification of enrollment processes • New rules in Idaho Administrative Procedure Act (IDAPA) implemented	State	Incomplete
Timeline Assumptions:	State legislative authority to implement already exists in HB 260.		
	No changes will be made in 2013. Concurrent 1915(b)/1915(c) authority will be used starting in 2014.		

L. Attachments*:*

1) 9/26/11 Meeting with Health Plans Summary
2) 10/26/11 Managed Care Redesign Long Term Care For Dual Eligible Beneficiaries Public Forum Meeting Notes
3) Letter of Support – Blue Cross of Idaho, Jack Myers
4) Letter of Support –Letter of Support – Windsor/Sterling Health Plans, Matthew Moore
5) Letter of Support – Idaho Commission on Aging, Sam Haws
6) Letter of Support – PacificSource Health Plans, Dave Self
7) Letter of Support – United Healthcare, Catherine Anderson
8) Letter of Support – Idaho Governor's Office

9) Text of relevant portion of Idaho House Bill 260
10) Tribal Notice Letter
11) Attachment 11 - Enrollee Grievance and Appeal Process for Integrated Services

Attachment 1 – September 26, 2011 Meeting with Health Plans Summary

Dual Eligibles Financing Model Discussion

September 26, 2011
2:00 p.m. – 4:00 p.m.
3232 Elder Street, Boise, ID 83705 208.334.5747
Conference Room D-West
Attendees:
DHW: Richard Armstrong, Leslie Clement Medicaid: Paul Leary, Natalie Peterson, Lisa Hettinger, Sheila Pugatch, Michele Turbert, Cynthia York, Robert Kellerman
Health Plans: Mark Bryan, Matthew Moore, Jeanne Phillips, Dave Self, Rhonda Busek, Catherine Anderson, Jenny Eidenbrook, Jack Myers, Jerry Dworak, Ricki Watts. Invited, not in attendance: Rich Rainey, Marja Wilson

2:00 p.m. – 2:15 p.m.	**Introduction and Overview** CMS released guidance on opportunities to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for individuals enrolled in both programs ("dual eligibles"). Idaho wants to work with Health Plans to gather ideas on how to pursue integration of primary, acute, behavioral health and long term services and supports for full benefit Medicare-Medicaid enrollees.	Leslie Clement
2:15 p.m. – 2:30 p.m.	**As-Is Landscape** Idaho Medicaid has a Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals enrolled in two participating Medicare Advantage plans. This model is a voluntary program that permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual. See attached handout.	Sheila Pugatch
2:30 p.m. – 3:45 p.m.	**To Be Discussion** Dual Eligibles Proposal to CMS Goals: integration, coordination, care management, shared cost savings, comprehensive all-inclusive plan	Natalie Peterson Paul Leary
3:45 p.m. – 4:00 p.m.	**Wrap-up and discussion of next steps** Letter of intent submitted to CMS – 9/25/11 Statewide long term care managed care stakeholder meeting 10/26/11 with panelists via video conference	Leslie Clement

To Be Discussion:

Recognizing the initial success with enrollments, why do you think the enrollment has been flat since inception?

- Limited access to members
- Need better access to members
- Initial success was hampered by CMS direction that limited direct contact
- High acquisition cost for health plans to start program

What are the barriers to enrollment?

- Current model is opt-in versus opt-out
    - Other States with opt-out plans have minimal disenrollment
- Inability to contact participants directly
- Lack of education to participants about the benefits of option
- Lack of continued marketing efforts

What are the strengths of the current MMCP?

- Individualized coordination of care
- Care manager assigned to participants
    - Frequent ER visits
    - Medication management
    - Medical home – incentivize prevention

What are the opportunities for improvement for the current MMCP?

- Broader benefit set
- Broader population reached
- Development of care management system
- Evaluate utilization of multiple risk levels (Hawaii has 6)

What are your thoughts about the fully integrated model?

- Very exciting opportunity to create coordinated care
- Opportunity to synchronize care
- Positive for administrative efficiencies
- Need to develop one set of processes for the population so they don't have to go to several places to get what they need, complaints, answers, etc.

What is the extent of overlap of the current Medicare and Medicaid provider network?

- Overlap approximately 50-60%
- Might want to consider hold harmless opportunities

What are your thoughts about how to gain greater flexibility in service use through blended funding?

- Identify needs and use funds to make good decisions for population
- Flexibility to use funds
    - This is a key element to capture what the flexible funding is supposed to achieve

- Aligning services sooner
- Consider HCBS light to provide services to those not yet institutional level but close

What are your thoughts to ensure access to the full continuum of services, including community-based care options?

- Think about how to incent providers to participate
- Phase in provider network
    - All in for existing network provides stability

What are your thoughts about whether certain subpopulations should be excluded?

- Different payments for different populations to recognize different services needed
- Idaho may want to consider a Cost + financing model
- May want to consider a phase in approach for certain populations

What is your readiness to handle the delivery of the full scope of benefits?

- Blue Cross recently completed a readiness assessment and has the core elements in place
- United is currently operating in 20 + States
- Need to take into consideration contract development timeframes
    - This is a very fast time line – would take considerable effort to implement by end of 2012
- Hiring care management clinical staff would take approximately 4-8 months

Attachment 2 – Managed Care Redesign Long Term Care For Dual Eligible Beneficiaries
Public Forum Meeting Notes October 26, 2011

OCTOBER 26, 2011
1:00 PM to 4:30 PM M.D.T.
12:00 PM to 3:30 PM P.D.T.

Agenda Topics		
Introduction and Welcome	Leslie Clement, IDHW Deputy Director	Start - 1:05
Opening Remarks	Richard Armstrong, IDHW Director	1:05-1:15
Background	Natalie Peterson, Medicaid Bureau Chief - Long Term Care	1:15-1:30
Panel Presentation	Keith Fletcher – President and CEO, Ashley Manor & AarenBrooke Place,– Represents Assisted Living Robert VandeMerwe – Executive Director, Idaho Health Care Association (IHCA) – Represents Skilled Nursing Dana Gover – Consultant, Access Concepts and Training and Personnel Assistance Oversight Committee (PAO) Member Represents Participants Raul Enriquez – Program Specialist, Idaho Commission on Aging Represents Delivery of Aging Services Jason McKinley – President, Idaho Association of Home Care Agencies (IAHCA) Represents Home Care Cathy McDougall – Associate State Director, American Association of Retired Persons (AARP) Represents Dual Eligibles	1:30-3:00
BREAK		3:00-3:15
Participant	Medicare-Medicaid Coordinated Plan Kurt Higgins – Personal Story	3:15-3:30
Panel Discussion and Responses to Submitted Questions		3:30-4:30

Question 1. The majority of dual eligibles is older than 65 years of age, but also includes individuals who are younger than 65 years of age and disabled. Should the managed care contracts include all duals or would you recommend a phased-in approach for certain subgroups of duals?

Remember that more dual eligible nursing home residents are younger these days, under 65, and there needs to be an improved option for them.

Agrees, both suggested carving out older individuals from this plan. Younger people are an ideal population for managed care, due to having fewer chronic conditions and greater potential for improvement and savings.

Start with those participants with chronic care needs. Look at managed care from a utilization standpoint, and not age. Ensure that you review utilization sub-groups; utilization distinctions are more important than age distinctions.

Agrees, don't use age use needs

Why have any exclusions? If it is a desirable option, leave it open for all right away.

Question 2: What performance requirements should Idaho Medicaid require of the managed care contracts to ensure that dual eligibles receive the best quality of care?

Everything in her slides should be required. It should not be based just on cost savings, but rather on ease of access and quality of life.

A holistic model should be used. It needs to be consumer-directed. Have providers, MCO's, and individuals at the table together so that the MCO's will be more accountable and responsive.

Prompt payment to providers is important

Strong State oversight is critical; be sure that Medicaid partners with the MCO to create benchmarks they are expected to attain. Ensure that those benchmarks include both provider and consumer satisfaction, and require timely access and payments. Meaningful benchmarks are critical; assuring access to services must be a benchmark as well as good pay for providers.

The consumer/care coordinator relationship needs to be measured; it must be strong for this to work.

Question 3: The managed care contractors are responsible for establishing provider contracts across the range of medical, behavioral health and LTC benefits. Other than requirements that ensure access to services, what other standards should be used by the managed care contractors to establish provider contracts?

We need legislation that says long standing (10Yrs.), established providers can not be excluded. Specialists are often out of network and that is a problem; they sometimes do not participate in managed care.

One managed care plan is a nightmare; rates are too low, and we can't get a contract with them. We have to jump through hoops through reimbursement. We need to let all providers participate in the network.

Lewin Group has some good research that says MCOs fail if they drive utilization to too few providers. Do not allow managed care add more bureaucracy. More rules would be a barrier to

access since we already have many rules with Medicaid and Medicare. Managed care fails if it's just based on price.

MCO should establish baseline standards for providers to ensure access to services. There needs to be real clarity to consumers about options, benefits, etc.

Reward good providers and don't reward bad providers. Quality standards need to line up with what will be paid for. All must agree on what good quality is. Quality should be defined without making it unnecessarily complicated.

Question 4: Should Idaho require the managed care contractors to include primary care medical homes for people with chronic conditions?

Yes. The Healthy Connections concept, which already includes medical homes, is good.

Idaho has a shortage of primary care physicians. It would be good to implement them, but it would be challenging due to the shortage of primary care physicians.

Medical home model is a good one but it is complicated to achieve in rural areas.

Question 5: What managed care contract requirements should be established to prevent and reduce inpatient hospitalization and nursing home admissions?

A RALF or facility may take a participant who has more intensive needs than they're capable of dealing with, and then 9-1-1 becomes the facility's nurse if no other resources are available.

Home care does not work for everyone; there is no guarantee of services in home care. MCO need to help move folks from higher cost settings to lower cost care settings where appropriate. It is a myth that people can be guaranteed the services that they're supposed to get in the in home care setting.
Contract needs to spell out the services and should exclude the "middle man." Remove the regulations "Handcuffs." Adopt uniform standards or supplement State standards. Choose the appropriate setting, even if it's outside the box.

Medicare and Medicaid need to be coordinated. Savings should not go to MCO, but $ should be used to improve care. Some States actually expand services under managed care. Numbers with NF Level of Care have been seen to decrease with managed care.

Coordinate plan with Medicaid and Medicare; coordination is key. Eliminate cost-shifting.

Question 6: How should advanced illness care planning and palliative care services be made available early in the onset of a life-limiting condition to assist the patient to make informed decisions in keeping with their personal values and avoiding expensive services that increase risk of harm and do not lengthen life or improve quality of life?

Huntingtons patients…it is important to catch conditions early enough to help people.

Everyone should have a right to live with dignity but provisions for services that do not help should not be paid for. It's not always the best thing to do everything possible in all situations. However, rights issues come into play. Managed care must meet humanity. The dual eligible population is likely to increase significantly by 2014.

Create incentives for people to have a "Living Will."

Question 7: How should patient choice be protected while offering the safest, most effective level of care and services in a streamlined, seamless manner during transitions between care settings, e.g. when discharged from the hospital?

Person-centered discharge planning is critical and it takes skill and training. Look at all options at discharge to deflect re-admittance; consider goals, needs, dreams, and facts. Use available supports/services to come up with the best plan; consider prevention.

MCO needs to be the one stop shop for learning about all options, not just select options. Options are often not available in rural areas. He likes the Oregon model, but does not like the Texas model. Meaningful interaction with the case manager is key. Managed care will force decisions upon consumers that they don't like, and so the quality of case management to work through that is imperative.

Not all providers like the Orgeon model. You need to assure true consumer choice; not just MCO only selected options/providers. Don't want the consumer getting a MCO's "preferred provider list."

You want government oversight to prevent provider favoritism by MCOs.

Question 8: What managed care contract requirements should be established for working with certified family home providers?

Need safeguards protecting people from limited choices since they are living in someone else's house. CFH's need to be part of the puzzle; there are more than 2,000 in Idaho.

Find a balance between personal and State responsibility. Gov. Otter talks about caring for your family.

Most people in nursing homes do not have home supports, CFH's should not be for profit. There's a place for it, but he struggles with the idea of the family being paid.

Question 9: What are the opportunities to reduce duplication and conflicting requirements between Medicare and Medicaid?

There should be a laundry list of options; look at streamlining and offer lots of options. Medicare will pay for brain surgery but not a bath aid.

MCO should use technology to track and coordinate care, avoid duplication, and catch medication errors.

Rules should not define what medical equipment is available to patients. Patient should decide what fits best.

Question 11: How should the Money Follows the Person demonstration project work with the managed care contractors to support the HCBS infrastructure and systems for the duals?

MFP excludes certain care settings, so it's already flawed since it determines what the settings can be. Don't exclude certain care settings.

MFP designed by CMS rules, not the States. It was designed to help people out of institutions. Sometimes there aren't enough community options, and that limits people's choices.

MFP and MCO dovetail well together.

Agrees. Helps provide good support services for people, and helps people to be connected with family in community.

Question 13: What managed care contract requirements should be established to support dual eligibles that choose to work?

We are not all sick; we are people with unique needs. Had 4 insurance plans at one time. Don't put us in a category. She wanted to know how long she'd be in the hospital when she had to go. You need to have good coordination with all providers whose services are being accessed.

Question 14: How should Idaho Medicaid receive ongoing input from duals, providers, and other stakeholders?

Ongoing work group with a variety of people involved to work with Leslie over time is key. Provider and public feedback is important. Legislation needs to be crafted together, or there will be a fight. These discussions need to continue. A 2012 implementation is too quick. It should slow down. We need to learn the lessons from last year's education reform because they went too fast without including important groups in the process. The public needs to be informed as this goes along.

The Community Care Council is a good forum to report to the legislature about this effort and how it is going. Give a report with a grade for each benchmark.

There needs to be an oversight committee with a real voice, not just a token to hear what the Department has already decided. We need active participation from the committee.

There should be more publicity so that the public can be involved in the process.

Use SILS and AAA to continue the public forums across the State. If we're not involved in this, we'll fight it to the bone.

Posting of questions and responses to website is good.

Attachment 9 – Idaho House Bill 260

According to Idaho's HB 260, 56-263:

MEDICAID MANAGED CARE PLAN.

(1) The department shall present to the legislature on the first day of the second session of the sixty-first Idaho legislature a plan for Medicaid managed care with focus on high-cost populations including, but not limited to:

(a) Dual eligibles; and
(b) High-risk pregnancies.

(2) The Medicaid managed care plan shall include, but not be limited to, the following elements:

(a) Improved coordination of care through primary care medical homes.
(b) Approaches that improve coordination and provide case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes, including mandatory enrollment in special needs plans, and that consider other managed care approaches.
(c) Managed care contracts to pay for behavioral health benefits as described in executive order number 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, Statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.
(d) The elimination of duplicative practices that result in unnecessary utilization and costs.
(e) Contracts based on gain sharing, risk-sharing or a capitated basis.

Attachment 10 – Tribal Notice Letter

IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

PAUL J. LEARY - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

April 3, 2012

Dear Tribal Representative:

The purpose of this letter is to let you know that Idaho Medicaid intends to submit a proposal to the Centers for Medicare and Medicaid Services (CMS) in order to participate in the Demonstration to Integrate Care for Dual Eligible Individuals, starting on January 1, 2014. We intend to submit the proposal to CMS no later than May 31, 2012. In this program, full dual eligible individuals (people who have Medicare and full Medicaid benefits) will be enrolled into a managed care health plan which will cover and coordinate their Medicare and Medicaid benefits, beginning on January 1, 2014. The proposal will be available on *www.MedicaidLTCManagedCare.dhw.idaho.gov* in April. This proposal follows the direction in the Idaho Legislature's House Bill 260, which asked for a plan for managed care for the dual eligible population.

Idaho Medicaid currently offers a voluntary Medicare/Medicaid Coordinated Plan (MMCP) under which Medicare benefits and some Medicaid benefits are coordinated by a managed care entity. The current MMCP will be replaced by the new program, under which all dual eligibles will receive all Medicare and all Medicaid benefits for which they are eligible through the health plan. The goal is to ensure that all dual eligibles receive coordinated, effective health care services.

Once CMS approves the proposal, Medicaid will work to replace the MMCP administrative rule in the Idaho Administrative Procedure Act (IDAPA) §16.03.17, collaborate with the legislature to revise Idaho Code §56-254, submit a 1915(b) waiver application, submit any needed waiver amendment requests to existing waivers, and submit the State Plan Amendments (SPAs) necessary to formally authorize the program.

Idaho Medicaid's development of the proposed program for dual eligible individuals will be reviewed as part of the Policy Update at the next quarterly Tribal meeting on May 2, 2012. Idaho Medicaid would like to receive your feedback about this change. Please contact Mark Wasserman with comments, questions or suggestions at wassermanm@dhw.idaho.gov or 208-287-1156 prior to April 30, 2012.

Sincerely,

PAUL J. LEARY
Administrator

PJL/rs

Attachment 11 - Enrollee Grievance and Appeal Process for Integrated Services

A. Contractor shall have a system in place for enrollees that includes a grievance process, an appeal process and access to the Department's fair hearing system that complies with 42 C.F.R. 438 Subpart F, and allows any enrollee the opportunity to challenge Contractor's actions related to any integrated service.

B. Definitions. Contractor's policies and procedures shall define the following terms with the following indicated meanings:

1. *Action* means the denial or limited authorization of a requested service; termination, suspension, or reduction of previously authorized service; the denial, in whole or in part, of a payment for a service; or the failure to act upon a claim in a timely manner as that term is defined in Section IV.
2. *Appeal* means a request for review of an action.
3. *Grievance* means an expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances, and appeals handled at the Contractor level and access to the Department fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)
4. *Notice* means a written Statement of the action the Contractor intends to take, the reasons for the intended action, the enrollee's right to file an appeal, and the procedures for exercising that right.

C. General Requirements. Contractor's grievance and appeal system shall include the following provisions:
1. *Filing Procedures.*
a. An enrollee may file a grievance or a Contractor level appeal.
b. An enrollee may be represented by legal counsel at their own expense, or by a person of the enrollee's choosing.
c. The enrollee or the enrollee's representative may file a grievance or an appeal either orally or in writing, either with the Department or with the Contractor. If filed with the Department it will be forwarded to the Contractor.
d. Unless the enrollee or the enrollee's representative requests expedited resolution, an oral request for an appeal must be followed by a written request.
2. *Timing.* A reasonable timeframe, no less than 20 days and not to exceed 28 days from the date of Contractor's action, for the enrollee or the enrollee's representative to file a grievance or appeal.

D. Notice of Action. Contractor's policies and procedures shall include the following requirements for notifying enrollees and providers of actions the Contractor has taken or intends to take:
The notice must be in writing and must meet the language requirements of 42 CFR 438.10(c) and (d) to ensure ease of understanding.
2. The notice must explain the following:

a. The action the Contractor has taken or intends to take;
b. The reasons for the action;
c. The procedures for exercising Contractor level appeal rights;
d. The enrollee's right to represent themselves or be represented by a person of their choosing;
e. The circumstances under which expedited resolution is available and how to request it;
f. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these service.
3. Contractor shall have procedures in place to ensure its notice of action is mailed within the timeframes specified in 42 CFR 438.404(c).

E. Handling of Grievances and Appeals. Contractor's policies and procedures for handling grievances and appeals shall include the following requirements:
Contractor shall give enrollees any reasonable assistance in completing forms and taking other procedural steps including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
2. Contractor shall acknowledge receipt of each grievance and appeal.
3. Contractor shall ensure that individuals who make decisions on grievances and appeals are individuals who:
a. Were not involved in any previous level of review or decision- making; and
b. If deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the Department, in treating the enrollee's condition or disease:
(1) An appeal of a denial that is based on medical necessity,
(2) A grievance regarding denial of expedited resolution of an appeal, or
(3) A grievance or appeal that involves clinical issues.
4. Contractor's process for appeals shall:
a. Provide that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date, and shall be confirmed in writing unless the provider requests expedited resolution.
b. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
c. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

F. Resolution and Notification.
Contractor shall dispose of each grievance and resolve each appeal, and provide notice as expeditiously as the enrollee's health condition requires, and not exceed the following timeframes:
a. *Grievances.* Disposition and notice to affected parties shall not exceed thirty (30) days from the date the Contractor received the grievance.
b. *Contractor level appeals.* Disposition and notice to affected parties shall not exceed thirty (30) days from the date the case is fully submitted for decision.
c. *Extension of timeframes.* Contractor may extend the timeframes from paragraphs a. and

b. by up to fourteen (14) calendar days if:
(1) The enrollee requests the extension; or
(2) Contractor shows that there is a need for additional information and how the delay is in the enrollee's interest.
d. *Requirements following extension.* If Contractor extends the timeframe, it shall give the enrollee written notice of the reason for the delay.
2. Notice of grievance dispositions shall be provided to the affected parties in writing stating at minimum:
a. A Statement of the grievance issue(s);
b. A summary of the facts asserted by each party;
c. Contractor's decision supported by a well-reasoned Statement that explains how the decision was reached;
d. The date of the decision; and
e. An explanation of enrollee's right to file a Contractor level appeal including the applicable timeframes and procedural steps.
3. For all appeals, Contractor shall provide written notice of the disposition stating at minimum:
a. A Statement of the issue(s) on appeal;
b. A summary of the facts asserted by each party;
c. Contractor's decision supported by a well-reasoned Statement that explains how the decision was reached; and
d. The date of the decision.
4. For appeals not resolved wholly in favor of the enrollee, Contractor's disposition notice shall also include:
a. The right to request a State fair hearing, and how to do so;
b. The right to request to receive benefits while the hearing is pending, and how to make the request; and
c. That the enrollee may be held liable for the cost of those benefits if the State fair hearing decision upholds the Contractor's action.

G. Continuation of Benefits While Contractor Appeal and State Fair Hearing are Pending.
1. *Timely filing.* Contractor's policies and procedures shall define "timely filing" for purposes of this section as on or before the later of the following:
a. Within ten days of the Contractor mailing the notice of action.
b. The intended effective date of the Contractor's proposed action.
2. *Continuation of benefits.* Contractor shall continue the enrollee's benefits if:
a. The enrollee or the enrollee's representative files the appeal timely;
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c. The services were ordered by an authorized provider;
d. The original period covered by the original authorization has not expired; and
e. The enrollee requests extension of benefits.
3. *Duration of continued or reinstated benefits.* If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
a. The enrollee withdraws the appeal.

b. Ten days pass after the Contractor mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
c. A State fair hearing office issues a hearing decision adverse to the enrollee.
d. The time period or service limits of a previously authorized service has been met.
4. Enrollee responsibility for services furnished while the appeal is pending. Contractor shall have a system in place to recover the cost of services furnished to the enrollee if the final resolution of the appeal is adverse to the enrollee and benefits were continued pending appeal to the extent they were continued solely by reason of this section.

H. Miscellaneous Requirements.
1. *Information about the Grievance System.* Contractor shall provide the information specified in this section about the grievance system to all providers and subcontractors at the time they enter into a contract.
2. *Recordkeeping and Reporting Requirements.* Contractor shall maintain records of grievances and appeals and must review the information as part of the State quality assurance.
3. *Effect of Reversed Appeal Resolutions.*
a. If the Contractor or the State fair hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
b. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with State policy and regulations.