

## Proposal to Integrate Care for Dual Eligibles Comment Summary

Comment/Source	Response
We support Idaho Medicaid's goal for better health outcomes, greater cost-effectiveness, and care being provided in the most appropriate setting. We also support Idaho Medicaid's interest in providing health homes for the following specific categories of individuals 1) A serious, persistent mental illness, or 2) Diabetes and an additional condition, or 3) Asthma and an additional condition. Because diabetes is the primary cause of ESRD, individuals with ESRD may be good candidates for health homes. (Fresenius Medical Care North America)	Section C(v)(e) uses and will continue to use the criteria for the new health home state plan service, which is expected to become available by the beginning of 2013. Many participants with ESRD may qualify for health home services due to having diabetes and an additional condition. ESRD is not a specific eligibility pathway for the health home state plan service, however. Even if individuals with ESRD do not qualify for the health home state plan service, the plans should follow the health home model of care as specified in Section C. More details regarding the health home model of care will be added to the Request for Proposal (RFP).
We also agree that dual eligible beneficiaries should be able to make plan changes based on changes in health status. Allowing a beneficiary to 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 is something we support. (Fresenius Medical Care North America)	Section D(ii) includes this provision. Additional detail regarding this process may be added to the RFP.
We have a suggestion regarding the proposal. The proposal states that the existing Idaho Medicare-Medicaid Coordinated Plan is a Medicare Advantage Special Needs Plan (SNP) and will cease in 2014. We support leaving duals already enrolled in MA or MA SNP plans outside of the demonstration project. Those individuals are already in a well-managed care environment and MA plans serve as another option for coordinated care plans. (Fresenius Medical Care North America)	For participants enrolled in the MMCP who do not select a plan, the state intends to explore ways to continue enrollment with the current plans as outlined in Section C(i). However, all duals are included in the demonstration. If existing MA or MA SNP plans participate, then duals with those plans will be free to remain with those plans, but they will also have the freedom to choose another plan.
The capitation rate should be based upon the actuarial rate and not the desired rate. The rate must be reflective of cost trends and must encourage service excellence and attract an adequate number of competent and professional service providers.(NAMI)	Yes. In accordance with CMS requirements, Section E(i) indicates that the actuarial analysis will be based upon a review of historical costs and projected costs. Tying reimbursement to quality measures will help ensure service excellence. Section E(ii) states that health plans will pay providers no less than the Medicaid rate. Detail will be added to the RFP regarding the rates paid to plans. The capitation rate will be set at an actuarially sound level that enables the plan to operate and have an adequate provider network.
Outcome data is critical and every effort should be made to collect the data in a timely fashion and to promptly make such data available to the legislature and the public in an easily-comprehended format. The performance data to be utilized is not described in the proposal. It must include: a. System Performance - availability of services, utilization levels, rate of critical incidents, time between inpatient discharge and first outpatient appointment, consumer involvement in the program planning, and use of evidence-based and promising practices b. Clinical Performance - symptom improvement, hospital diversion rates, identification of medication gaps, quality of life improvement (housing, employment, relationships), re-hospitalization level, emergency room use, homelessness, incarceration, and involvement with the criminal or juvenile justice systems c. Administrative Performance- consumer and provider satisfaction surveys, service appeals, service denials, complaints/grievances, call pick-up, claims payment rate, network turnover, timeliness of data reporting. (NAMI)	Revisions have been made to Section F(ii) to incorporate the system/clinical/administrative performance framework. Some of the specific measures, like utilization, re-hospitalization, satisfaction surveys, service denials, complaints/grievances, and claims payment rates are now included. CMS will be providing certain required quality measures and the state and CMS will collaborate and build on those. Much more detailed information will be added to the quality measures as the state and CMS develop the Memorandum of Understanding (MOU).
There must be a mandatory process for reporting by a health care team to the managed care provider when a person living with mental illness drops out of treatment in unstable condition and direct follow-up by a mental health professional representing the managed care provider with the person living with mental illness to make sure that that individual is receiving services from another mental health provider. A person living with mental illness who is unstable may not have the capacity to reconnect with new services without the assistance of this follow-up service. This service is essential to prevent individuals living with mental illness from 'falling through the cracks' with severe behavioral, social and irreversible health consequences.	RFP will have language so that the care management team must develop a notification/communication process if an individual is not participating in the established care plan (i.e., missed appointments, discontinued services, etc).
A change of mental health providers for a person living with mental illness can be a traumatic and dangerous event. It often takes a long time to create a trusted relationship with a mental health provider. It can take years for a mental health service provider to properly understand a particular individual's illness and determine the right mix of medications and therapy. Every effort should be made to minimize changes of mental health providers, such as during the transitions into and between managed care plans. Consideration should be given to continuity of care. A "grandfather" provision should be required so that individuals living with mental illness can continue with their current mental health provider, if they choose, and such provider will be reimbursed under the plan. (NAMI)	Network adequacy requirements in D(ii) will help to minimize changes in any providers by ensuring a strong provider network. A requirement that health plans consider continuity of care issues when developing their networks was added to D(ii). More detailed information regarding network adequacy requirements will be added to the RFP. Although continuity of care cannot always be guaranteed, requirements will be in place to ensure that needed services are readily accessible.
There should be a formal requirement for the managed care provider to develop and implement an assertive outreach program to maximize the number of mental health providers included under the plan. Plans should be required to deliver and document education to providers regarding plan rules and communication requirements among the members of the care team. (NAMI)	More detailed information regarding network adequacy requirements will be added to the RFP. Although continuity of care cannot always be guaranteed, requirements will be in place to ensure that needed services are accessible. Plans and providers must offer the services under development in the State's upcoming behavioral health managed care program.
To minimize confusion surrounding the change to integrated care teams and managed care plans, independent enrollment brokers should not be used. Plans should be required to inform and recruit all individuals who are eligible for coverage under the plan using internal marketing staff. To avoid confusion and conflicting messages, the State and managed care plans must coordinate their communications to clearly assist beneficiaries in evaluating plan options. The State should work with the plans and beneficiary focus groups, including people who live with mental illness, to develop models for member materials so that information is clear and consistent. Passive enrollment information should be in plain English and all options for changing enrollment should be explained to the beneficiary at the time of passive enrollment notification. The plan should provide objective enrollment, benefit, and appeals assistance. (NAMI)	Section C(i) has been revised to include information on how the State, CMS, the plans, and the enrollment broker will collaborate to provide clear and consistent information. Section C(i) was also revised to include a requirement that participants be notified how to enroll into a different plan at the same time they're notified that mandatory enrollment will occur. The enrollment broker remains in place, because it should help to minimize confusion to have an independent, third-party providing objective information to assist with enrollment. The enrollment broker will have no financial incentive to direct participants to a particular plan. Additional detail regarding enrollment processes will be developed.
If a patient who meets nursing home level of care chooses a particular care setting, but the plan chooses a lower cost care setting... can the plan withhold payment to the setting the patient chose? Or require discharge? a. We recommend that patients have the right to choose their care setting within reason. This should be a negotiation between the plan and the participant. (IHCA)	Section C(ii) outlines roles and responsibilities. It states that the participant should play as active a role as possible and principles of person-centered care should be followed. Ultimately, the plan must offer all medically necessary services the person qualifies for, but the care team should collaborate with the participant in choosing the most appropriate setting possible. Details may be added to the RFP clarifying roles of participant, care management team, and health plan. If a participant disagrees with a health plan decision, an initial appeal can be made with the health plan, and an external appeal can then be made if relief is not granted.
Will the current Medicaid provider payment be the minimum payment required by the plan? a. We recommend that the current rate be required by the plan and that savings are generated by case management...not rate management.(IHCA)	Yes. Section E(ii) was revised to say that the "health plan will pay providers a minimum of the current Medicaid rates for services rendered."

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Require that cost reports be maintained, to ensure that the assessments can continue, and structure the UPL to be paid as a rate adjustment, not as a lump sum. This will require a statute change that will need to be finalized in the 2013 legislative session. a. We recommend the department work with IHCA and others to rewrite the statute to comply with these objectives. (IHCA)	Dual eligible participants are not included as a part of the Medicaid days calculation.
Will the federal access requirements (and the rules being developed by Idaho) still apply to a managed care plan? (IHCA)	Section D(ii) was revised to indicate that the health plan must comply with 42 CFR 422.112 requirements for access to services. Also indicated that Medicare and pharmacy requirements will be based on Medicare requirements.
How can balance be assured between family/patient choice and case management decision making? (IHCA)	Section C(ii) describes how the participant should play as active a role as possible, and how a person-centered-approach should be used. Details may be added to RFP to further clarify roles and responsibilities.
Ensure that perception between independence in non-institutional settings and services provided by SNFs are put on an even playing field. (IHCA)	Section C(ii)'s care model should help ensure that decisions in the participants' best interests are made.
Will expense for home health travel mitigate perceived savings from non-admission to SNFs? (IHCA)	Idaho currently has a robust array of home and community based services to offer choices to individuals to remain in the community. The cost for these services is less than those provided in institutional settings.
How will the cost savings be measured? Is there expected to be cost savings? (IHCA)	Section E(i) indicates that the PMPM will be based in part on anticipated savings. The exact method of determining cost savings will be determined by the actuaries. CMS will not allow the proposal to move forward unless there are projected savings. The actuarially sound rate range, which will anticipate some cost savings, is expected to be in the RFP.
Is there an expectation for assessments and care planning for the home setting? (IHCA)	Yes. C(ii) indicates a care plan requirement for participants regardless of whether they're in a home setting. Detail may be added to the RFP so that unnecessary care planning does not have to be done for healthy individuals.
What is the difference between person-centered care and those services provided by a SNF? (IHCA)	Similar principles should apply in various settings (getting the participant's input, supporting the participant's goals and preferences, etc.). The focus of the demonstration is to develop a person-centered plan of care that is not location-centric but participant-centric.
Will there be any beneficiary satisfaction surveys? (IHCA)	Yes. Section F(ii) was revised to include satisfaction surveys.
The report fails to address that those placed in a nursing home setting are generally more medically complex than those in a non-institutional setting, resulting in a higher number of hospital admissions. (IHCA)	While people who are more medically complex may have a higher number of hospital admissions, focusing on a system of coordinated care and in conjunction with other CMS initiatives, hospital admission / readmission rates should decrease.
Is there a process for the state to immediately intervene on behalf of the beneficiary if required? (IHCA)	At any time, participants may contact Medicaid, bring issues to the attention of the MCAC and PAO committees, file appeals, contact law enforcement or 9-1-1, etc.
In section ii 'Payments to Providers' (lines 721 thru 740), include a bullet point for 'Prompt Payment' language and define it to mirror the language currently in effect with Medicaid. a. Currently, the state of Idaho can process claims on a Thursday and payment is in the provider's bank account the following Thursday (1 week turnaround from billing to payment). (IHCA)	Added a requirement for prompt payment of claims in Section E(ii). States that payment must be "comparable" to the Medicaid timeframe.
Include/clarify language on section D. of lines 611 thru 613 and consider changing the sentence 'Contractor shall maintain a network of appropriate providers supported by written agreements.' to 'Contractor shall establish written agreements with any willing provider.' a. We would want to be able to provide service to any resident or client that may wish to receive services from us. The current language may allow the contractor to dictate and/or limit the providers that the resident/client can use. (IHCA)	There is no intent to require the contractor to work with 'any willing provider,' but there are requirements to ensure that rigorous network adequacy standards are met. Additional detail regarding rules for out-of-network providers will be added to the RFP.
In K. Workplan/Timeline, there is no Key Activity/Milestone of when the contractors will issue agreements to providers to execute. The three-way contract between the Health Plans, CMS, and the State is set to be completed in September 2013; however, there appears to be no timeline of when the providers will be expected to review and execute the agreements with the respective contractors. (IHCA)	The timeframe for contacts with in-network providers will be outlined in the RFP. In addition, the website will be updated to ensure stakeholders are aware of activities related to this demonstration.
This program relies heavily on input and direction regarding the stated preference by a patient or responsible party on that patient's preferred care setting (lines 113-116, line 304-305). In many cases in the skilled nursing facility (SNF) setting, the patient and/or family member is unable or unwilling to make that decision. The decision will then defer to a case management worker who may be financially incentivized to send that patient to a setting where the case worker may be paid more to manage that patient's care rather than a setting that is best suited to the patient's needs. (Rick Holloway Western Health Care)	The Section C care model addresses this issue. The care management team members, who contract with but are not employed by the health plan, are the individuals involved in selecting the appropriate care setting.
Will the requirement that SNFs complete frequent Minimum Data Set (MDS) assessments on Medicare and Medicaid patients be removed once the transition to this system is completed? If MDS's would still be required to be completed in the SNF setting, would the same assessments, with the same frequency, also be required of any patient who would have been admitted to a SNF but was diverted to a home setting? What assessments and care planning would be required to be completed once that person is diverted from a SNF to a home setting? In other words, it is not equitable to require massive assessments and care planning, as well as provision of care on a 24-hour basis, in a SNF setting but remove all of those requirements if that person is in a home setting. (Rick Holloway Western Health Care)	This proposal does not address changes to the federally required Resident Assessment Instrument process for nursing facilities. Nursing facilities will continue to complete the MDS assessments. Care planning will be required for duals regardless of setting (see Section C(ii))
There are several references to "person-centered" care (line 312, line 320, for example). How is "person-centered" care as stated in this program different than the individually developed care plans and treatment programs written and implemented in Idaho's SNFs, and verified by state surveyors on annual visits? (Rick Holloway Western Health Care)	Details of person-centered care as applied to this program have not been finalized, but Section C(ii) indicates that the participant will play as active a role as possible in care planning with the care management team. The focus of the demonstration is to develop a person-centered plan of care that is not location but participant centric. More detail may be added to the RFP.

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<p>Listed as a "Potential improvement target for quality measures" is the number of hospital and skilled nursing facility admissions (line 764 and 766). How will either of these be an indicator of quality? If there are increased hospital and nursing home admissions, it could be that the population is aging (which is expected) and the incidence of admissions to a health care facility increases as a person ages. It could also be that the case workers identify patient conditions that require inpatient care even though the beneficiary would have delayed the care for a variety of reasons. But more problematic is a significantly decreasing number of inpatient admissions. If health plans deny admission to beneficiaries even though inpatient admission is warranted, the state may not know needed care was denied until after the patient dies. Why are there not quality measures that include beneficiary satisfaction surveys, tracking complaints from other providers (such as a hospital or SNF who was refused payment by the health plan despite following all of the health plan's requirements), improvements in a beneficiary's ability to perform ADLs and be self-sufficient, increasing practices of healthy lifestyle choices by beneficiaries, and so on? We have had many situations where Medicaid beneficiaries who were being cared for in a home setting came to a SNF after a hospitalization due to infected decubitus ulcers acquired while in the home setting, unmanaged diabetes or coronary/respiratory issues, significant decline in function, and so on. What will be put in place to make sure the quality of care in the non-institutional setting is maintained? (Rick Holloway Western Health Care)</p>	<p>The Section C(ii) care model should help ensure the quality of care in all settings for the participant. Quality measures are being developed and will be refined in the RFP. Satisfaction surveys are now included in Section F(ii) as a quality measure.</p>
<p>At least part of the rationale for embarking on this project is because of the emphasis of CMS to reduce rehospitalization among nursing home residents (lines 912-917). This section states, "CMS research has indicated that 45% of hospital admissions for those receiving Medicaid nursing facility services are preventable." However, the report which is referenced here says nothing about "45% of hospital admissions" for dual eligible are from nursing facilities. It says that "26% of rehospitalizations may have been avoidable" but it fails to mention what constitutes an "avoidable" and "unavoidable" rehospitalization. What is striking in the original CMS report is that Idaho is the <u>second lowest</u> State in the nation regarding hospital readmission rates from a SNF. The state may be placing a considerable amount of resources and emphasis implementing a solution which is in desperate need of a problem if it is trying to reduce rehospitalizations among nursing facility patients. The glaring problem with the entire report is that it lists nursing homes as the primary care setting in which patients are readmitted to a hospital, but ignores the fact that patients in a SNF are considerably more medically compromised than patients in a home care setting.(Rick Holloway Western Health Care)</p>	<p>Medicaid recognizes the need for the careful development of quality measures that incentivize quality care. The link has been updated, and it does state that "approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and \$2.6 billion in Medicare expenditures in 2005." Although Idaho Medicaid recognizes that Idaho statistics on rehospitalization may differ from national averages, the focus is avoidable, needless rehospitalizations, even if the numbers may be smaller than in other states.</p>
<p>Will the health plans dictate to beneficiaries where they can go to receive inpatient hospital or SNF care? Will they be allowed to direct patients to and away from certain facilities? Will there be oversight regarding which hospital/SNF/health care provider is used by the health plan and which are excluded? What quality measures will be in place to be sure beneficiaries receive the level of care deemed appropriate by their attending physician? My biggest concern about this program is it places total control over the health care services provided to beneficiaries without any oversight or monitoring. If bad patient outcomes occur, there does not appear to be any process for the state to immediately intervene and require the plan to provide medically necessary care.(Rick Holloway Western Health Care)</p>	<p>Network adequacy standards in D(ii) must be met, which means that they must have appropriate access to hospitals/SNF's. Section C(ii) indicates that the care management team (not the health plan), which includes the primary care physician, will be the primary agent deciding where care is delivered. Quality measures will be developed and refined.</p>
<p>Will the payment rates to hospitals and SNFs be negotiated directly between the health plans and the providers or will the state have any input or influence? If the health plan sets payment rates too low and a provider in a given area refuses to accept the low rates, the plan enrollees may be forced to travel 50 miles or more to another provider to receive health care services. (Rick Holloway Western Health Care)</p>	<p>The state will have influence. In Section E(ii), a requirement was added stating that health plans must pay no less than Medicaid rates.</p>
<p>Will the payment rates established between the health plans and health care providers be made public? Typically, these negotiated rates are a tightly guarded trade secret between the health plans and providers. Additionally, health plans or providers could engage in collusion or price fixing if the payment rates between different health plans and providers were made public. (Rick Holloway Western Health Care)</p>	<p>There are no current plans to make rates public, although the public will know that provider rates are no less than Medicaid rates.</p>
<p>Will there be a limitation on the amount of times a health plan could require an enrollee to move if the health plan finds another provider who will accept a lower rate for that patient? For example, a patient could be in SNF "A" at a negotiated rate of \$180 per day, and the health plan decides to move the patient to SNF "B" because that facility will accept \$178 per day. Two months later, the health plan moves the patient to SNF "C" because that facility will accept \$175 per day. Each move is extremely disruptive to the life of the enrollee, but there appears to be no limit on the number of times a health plan could transfer a patient if it finds another facility which will accept a lower rate. Just as critical is the ability of a health plan to move a patient potentially 100 miles or more away from their family and community only because the health plan finds a provider in another community in Idaho which will accept patients at a lower rate. Is there any restriction on how far a health plan can direct a patient away from his/her home or family, or will the health plan be required to place an enrollee needing SNF care in the community from which he/she resided prior to hospitalization or the acute/chronic episode which subsequently required SNF care? (Rick Holloway Western Health Care)</p>	<p>The care model in Section C(ii) involves a care management team that includes a physician and care manager not employed by the health plan. This care team coordinates the care, not the health plan. This will minimize a risk of a conflict of interest.</p>
<p>Will the payment rates established between health plans and SNFs be a factor when determining the Lower of Cost or Charges (LOCC) limitation on SNF Medicaid rates for non-dual eligible? If so, this would by default reveal the payment rate negotiated between the health care plans and the SNF providers, which could again lead to possible collusion or price fixing problems. (Rick Holloway Western Health Care)</p>	<p>Lower of Cost or Charges will still apply.</p>
<p>How will patient days and acuity scores for the health plan enrollees be considered in the derivation of facility-specific Medicaid rates for non-dual eligibles? (Rick Holloway Western Health Care)</p>	<p>Dual participants will not be included as a part of the Medicaid days calculation.</p>
<p>What happens to the current 2.7% across the board rate reduction for all Medicaid patient days when the dual eligible population enters a health plan? I assume that will go away for all dual eligibles in a health plan, but I just need to be sure. (Rick Holloway Western Health Care)</p>	<p>Health plans and providers will contract, but rates may not be lower than Medicaid rates.</p>
<p>As we still have a SNF provider tax program in Idaho, and likely will have the program in the foreseeable future, how will non-Medicare days and Medicaid days be counted to calculate the provider tax and UPL payments? Will the UPL payments be made only based on non-dual eligible Medicaid patient days? Will the provider tax be calculated based on total days less Medicare only days? (Rick Holloway Western Health Care)</p>	<p>The patients covered by the MCO will no longer be part of the UPL calculations.</p>

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<p><b>Incentives to Provide Effective Preventive and Supportive Mental Health Services</b> It is imperative that the financial incentives built into the system reward high quality care and effective preventative practices. It has been demonstrated that it is possible to save money by employing effective preventive and support services for several chronic conditions such as asthma and diabetes. There is evidence that bundling traditional physical health with mental health treatment can reduce the cost of traditional medical care and reduce psychiatric hospitalization. However, these demonstrations placed the burden for the cost of psychiatric hospitalization on the MCO.</p> <p>1. If the cost of hospitalization is borne by the state, the MCO has an incentive to place people in state hospitals and to delay their return to the community as long as possible. Unless the full cost of hospitalization in state hospitals is somehow charged to the MCO, there is no incentive to prevent hospitalization or to have robust mental health supports to prevent recidivism.</p> <p>2. The system should also provide incentives for preventing people with SMI from entering the criminal justice system or jails, or committing suicide. All of these events can actually lead to cost shifting or cost savings for the MCO unless the payment system provides disincentives for these events. (Disability Rights Idaho) (DRI)</p>	<p>It is agreed that it is imperative that the financial incentives built into the system reward high quality care and effective preventative practices. In Section C(ii), the care management model allows the care management team, which will not have a financial incentive to direct care to inappropriate settings, to drive the care decisions. The issue of quality measures for people with SMI will be addressed in the RFP.</p>
<p><b>DD Services and Supports</b> The PMPM method does not by itself provide incentives for effective DD supports services or treatment. The goal of these supports is to increase the capacity of the person for self determination, independence and community integration. The success of such services is not measured by their physical health status or need for more expensive medical treatment. Short of institutional placement, there is no consequence to the MCO for providing inadequate or ineffective services and supports. Placement in a state facility like SWITC would even be a net savings to the MCO and for certain individuals ICF/ID placement could be a savings over a robust and effective community supports plan. To be effective, there must be a strong incentive to provide effective developmental services and supports. This can only be accomplished with a robust and accurate quality assurance system and well designed incentives to meet the expectations of that system. We are not aware of any examples of such a system. Traditional health insurance plans do not have expertise or experience with these services. (Disability Rights Idaho) (DRI)</p>	<p>It is agreed that a PMPM does not by itself provide the appropriate incentives to promote quality. Section C(ii) should help to address this through the authority given to the care management team. Quality measures will be developed to ensure appropriate services for the DD population.</p>
<p>1. The MCO should be required to contract with a highly qualified, independent entity to evaluate the quality and effectiveness of DD supports and services. 2. IDHW should consider carving out DD supports and services from the plan or preserving them as a fee for service system. With a robust system of quality assurance and care management practices. (Disability Rights Idaho) (DRI)</p>	<p>Medicaid recognizes that special attention will need to be paid to developing an appropriate program for the DD population. The specific features of how services are delivered to the DD population will be developed accordingly.</p>
<p><b>Enrollment:</b> 1. Require that consumers have at least 90 days to make a choice among plan providers. 2. Require plans to contract with community-based organizations such as Independent Living Centers, and others. 3. Include programs for people with mental illness, to educate potential enrollees about their options and to assist them in selecting delivery systems that best serve their individual needs. 4. Allow enrollees to change plans at any time, without imposing a lock-in period. (Disability Rights Idaho) (DRI)</p>	<p>1. Initial enrollment will take place in October 2013 and per Section D(ii), a participant may change plans in any month. 2. Plan must meet network adequacy requirements per Section D(ii) for all Medicare and Medicaid services. 3. Enrollment broker will help educate all potential enrollees about their options, per Section C(i). 4. With proper 15 day notice, enrollees can change plans in any month per Section D(ii).</p>
<p><b>Provider Networks:</b> Many dual eligibles have longstanding, beneficial relationships with providers that might not be in the existing network of a health plan or delivery system that participates in the program. To maintain continuity of care and respect these relationships, participating plans should: 1. Maintain an open network provider system in order to contract with providers that are not currently in the network. 2. Offer single case agreements that allow participants to continue seeing their current provider without arbitrary limits on the duration of the relationship. 3. Require that all providers are trained on independent living and mental health recovery approaches. (Disability Rights Idaho) (DRI)</p>	<p>Although continuity of care can not always be guaranteed, network adequacy requirements will be created to help address continuity of care and ensure adequate access. Care will be coordinated amongst the providers, and participants will have access to all necessary services, but not all providers will be required to be trained on independent living and mental health (MH) recovery approaches as not all providers will deal with those issues.</p>
<p><b>Long Term Services and Supports (LTSS):</b> The goal of LTSS for dual eligibles should be to promote their independence, choice, dignity, autonomy and privacy. LTSS must emphasize community and home-based services over institutional care in compliance with the Olmstead v. L.C. and E. W. decision. 1. LTSS services and should be based on conflict of interest free comprehensive evaluations which include an evaluation of functional status, social and vocational needs, socioeconomic factors, personal preferences, and the ability to obtain accessible services. 2. Require plans to maintain current levels of LTSS until a comprehensive assessment is conducted. 3. Contract with LTSS providers who have the capacity and expertise to meet member needs. 4. Have the beneficiary play the central role in the LTSS assessment and in the development of an LTSS plan. 5. Support family care giving through designation of family members as paid aides when consumers request this, as well as through respite services. 6. Provide personal care assistant services, including an option for self-directed services. 7. Ensure that people with developmental disabilities (DD) have the opportunity to participate in the My Voice, My Choice HCBS Waiver option. 8. Ensure that people with both a developmental disability and a mental illness have coordinated LTSS from providers with expertise in supporting both conditions. (Disability Rights Idaho) (DRI)</p>	<p>The preference of HCBS over institutional care is indicated (see Section B), but more of the details will be added in the RFP. 1) Participants must continue to have access to LTSS services for which they qualify. 2) No exact requirements for an amount of LTSS are in place; it will depend on need. 3) The RFP will include network adequacy requirements to ensure that qualified LTSS providers will be available. 4) Section C(ii) indicates that person-centered care is required, and that the participant should play as active a role as possible. 5) As is the case currently, some services can be provided by qualifying family members. 6) Personal care services and self-directed services will remain options for qualifying participants. 7) People with developmental disabilities (DD) have the opportunity to participate in the My Voice, My Choice HCBS Waiver option. 8) Details regarding care for DD and MH and dually diagnosed populations will be added to the RFP.</p>
<p><b>Care Coordination:</b> Most health insurance companies have no experience with community based services for people with SMI or DD. Typical health plan care coordination generally consists of having a nurse call the member occasionally on the phone. Case Management and Service Coordination services for people with SMI or DD must be much more "hands on". It must include regular face to face meetings and intervention or advocacy on behalf of the member with other providers and community contacts such as landlords or the courts. Traditional health plan care coordination must not replace these vital support services. Plans must be required to contract with qualified and experienced DD service coordinators and SMI case managers, and whenever possible to continue with the member's current services. The care coordination team must include a LTSS provider or coordinator (could be the case manager or the TSC) who is responsible for maintaining the LTSS. Few PCPs are able or willing to perform this function. LTSS care coordinators will often be needed for people receiving home care LTSS as well. (Disability Rights Idaho) (DRI)</p>	<p>Section C(ii) requires a care coordinator, and LTSS services must be available to qualifying individuals. More details, such as a possible requirement for annual face-to-face meetings, may be added to the RFP. However, a separate care coordinator specifically devoted to LTSS is not anticipated. The care coordinator will be responsible for coordinating LTSS services for qualifying individuals, however.</p>

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<p><b>Crisis Services:</b> People who require LTSS for physical disability, DD, or SMI are at risk for crises in their lives and in their care needs. Plans will need to be able to quickly approve and provide additional services to deal with a crisis caused by a change in the person's physical or mental health status, the imminent loss of living arrangements, unpaid supports, or other catastrophic events. The ability of the system to respond to unexpected crises in the community without resorting to institutional placement should be a key requirement of the plan. The plan should also be well coordinated with non-Medicaid crisis services and be able to access them when needed.</p> <p>Compliance with Olmstead v. L.C. and E.W. and Best Practices for community based services. The MCO must be in full compliance with the community integration mandate of the Americans with Disabilities Act (ADA) and the Supreme Court decision in Olmstead v. L.C. and E.W. Although the ADA has lesser implications for private health insurers, the Medicaid program must comply with Title II of the Act and the community integration mandate. This will require the contractor to make community services available in cases where institutional placement would be less expensive. It also requires services to help prevent hospitalization for people with mental illness. 1. There must be incentives and requirements in the plan to provide for recovery oriented, person centered plans of service. 2. The plan must allow for self directed services in all areas of long term services and supports including mental health. 3. DD services should emphasize self determination, community integration, employment opportunities and training for eligible individuals. The proposal for a single MCO contract for all Medicaid services for all people with dual eligibility is unprecedented and moves Idaho into uncharted territory in LTSS models. IDHW should be extremely cautious and move slowly and deliberately toward this project. Planning to implement it in the current time frame with such an array of both known and unknown variables (e.g. the Mental Health MCO contract, the implementation of the ACA, the pending decision in the Supreme Court on the constitutionality of the ACA, the efforts to redesign DD services, several pending federal lawsuits) may be too ambitious and ill advised. If Idaho does proceed at the proposed pace, there are serious issues to be addressed in the areas of DD services, mental health services and other LTSS.(Disability Rights Idaho) (DRI)</p>	<p>Self-direction is introduced in Sections D(i) and D(ii). Section D(ii) also makes clear that the ADA must be complied with. Details will be added in the RFP. Further, Section D(ii) requires phone coverage to be provided 24 hours a day by a nurse, and it also requires 24-hour physician coverage, provided by the physician or with an on-call arrangement.</p>
<p>1. Idaho's Managed Care plan must include requirements for Managed Care entities to have previous experience in providing long-term services including Home &amp; Community Based Services. Idaho's demonstration project must include requirements for Managed Care entities to have previous experience in providing long-term services including Home &amp; Community Based Services. The plan should target specific sub-populations across differing disabilities and age groups to test and ensure program functionality and make needed adjustments that best align plan and program components before the entire dual eligible population is included. Experience is limited in managed care for higher risk disability populations, so Idaho should not rush to implement a full managed care program which could result in widespread disruption in services and negative health outcomes. Testing the plan is key and will require at a minimum of 2-3 years of experience to ensure that appropriate quality and performance features are in place and adequate payment rates set for both the service providers. (Dana Gover)</p>	<p>The health plans will contract with the care team/providers who will have appropriate qualifications. It is expected that plans will contract with a number of qualified providers who have extensive experience.</p>
<p>2. Idaho's plan must change to a voluntary opt in, opt-out model of enrollment ensuring that program participants have personal choice in their services and are committed and willing participants in utilizing the coordinated services that the model is designed to provide. Lines 105-111 "...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." Idaho's draft managed care plan does NOT encourage or provide incentives for managed care entities to actively recruit participants. Idaho is utilizing a mandatory enrollment model requiring duals to enroll into a managed care plan. Duals will have no choice to opt-in on a voluntary basis or opt- out if the providers don't meet our unique medical needs. If the managed care providers offer quality services and meet people's unique medical care needs a mandatory model is unnecessary. People choose services that they are aware of and services that will improve quality of life.</p>	<p>A different approach is used in the proposal. To ensure the program's feasibility, it was necessary to have a sufficient number of participants enrolled. Participants will have the choice to self-direct, change plans in any month, appeal health plan decisions, etc. There is an incentive for MCO's to attract participants as Section D(ii) indicates that participants may choose their plan.</p>
<p>The right to "opt out" of Medicare alone is not adequate to protect dual eligibles from harm. Out of network providers must be available for those with specialized needs. A dual eligible who is mandatorily enrolled into a managed care model may experience a disruption in care and opting out into another managed care plan may not meet the person's medical needs.</p>	<p>Mandatory Medicaid enrollment will be used. A more detailed approach to out of network providers will be developed for the RFP. Need to determine best way to allow access to out-of-network providers when necessary but encourage the use of network providers and encourage provider participation in network. Section D(ii) addresses network adequacy issues, and more detail will be added into the RFP.</p>
<p>3. Institute a Sound and Accountable Consumer – Driven Quality Management and Improvement System</p>	<p>See Section F(ii) and the quality measures discussion.</p>
<p>The draft plan does not include an unbiased third party that will provide oversight unrelated to the Managed Care organization and the State of Idaho to ensure duals will receive timely and quality services that meet our complex medical needs. (Dana Gover)</p>	<p>Added language in Section E(i) to indicate that the State and CMS will review performance with respect to quality measures.</p>
<p>Idaho must oversee and ensure that managed care programs provide a quality management process that includes independent third-party monitoring, written evaluation of the managed care entities performance and assessment of various quality care indicators. These parameters need to be measured specific to the needs of persons with disabilities and should be based on principles outlined in the managed care plan. (Dana Gover)</p>	<p>Added language in Section E(i) to indicate that the State and CMS will review performance with respect to quality measures. Further details on quality management and whether a third-party will be involved will be included in the RFP.</p>
<p>The plan requires managed care entities to comply with Federal and State Laws by citing the laws on page 19. However the draft plan doesn't clearly describe or emphasize requirements of program and physical access for individuals with disabilities. (Dana Gover)</p>	<p>Detail may be added to RFP.</p>
<p>Additionally, managed care organizations serving Medicaid beneficiaries via government programs should be expected to be model employers in practicing affirmative action in the hiring of qualified workers with disabilities. Section 503 of the Rehabilitation Act requires affirmative action among federal contractors in the hiring of qualified candidates with disabilities. Contractors to Medicaid, a federal-state partnership program that provides significant services to those with disabilities, should take similar responsibility for achieving fairness in the employment of individuals with disabilities. (Dana Gover)</p>	<p>Detail may be added to RFP.</p>
<p>5. Self-direction must be clearly outlined and defined in the draft plan.</p>	<p>Section D(i) includes self-direction, but details will be added to RFP.</p>
<p>Idaho's draft plan doesn't spell out clearly a dual's personal rights and choice as guiding principles in the self-direction or person centered planning discussion. Self-direction is discussed in the plan but only states that duals can choose and change staff. The managed care plan should clearly follow Idaho Statute Title 39, Chapter 56 outlining the self-direction model that provides individuals the right to choose who they interview, direct, schedule, train, hire and fire. This includes the hiring of family and friends to assist with personal assistance needs. (Dana Gover)</p>	<p>Self-direction is incorporated in Section D(i), but Medicaid recognizes that details will need development.</p>

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The plan does not address the budgeting authority that participants have under the DD Waiver. The plan states that there will be changes to the Waivers but the specifications of these changes are not described. (Dana Gover)	Table A shows that all Medicaid benefits will be included, and self direction of the individualized budget is available under IDAPA 16.03.10.703.13. Detail may be added to RFP.
Idaho's Draft Managed Care plan does not outline requirements for the Managed Care entity to provide adequate reimbursement rates. No matter how much effort and good intention Idaho and CMS incorporates into Managed Care programs, if reimbursement rates are not adequate, then neither providers nor managed care organizations will be interested in participating. Or, even if they are interested at first, these programs will not be sustainable. Getting the rates right for integrated care is imperative. Proper rates ensure that neither the federal government nor the states are paying too much for services, but they also ensure that Managed Care Providers and network providers are in the position to provide the right services, at the right time, to the right person. (Dana Gover)	Added language in Section E(ii) to indicate that health plan must pay, at minimum, the current Medicaid rates.
Idaho must ensure transparency in their rate setting and demonstrate that these rates are actuarially sound. In any managed care payment process intent on meeting the needs of those with significant disabilities, such payment rates must account for severity of condition and be adjusted for varying levels of risk. (Dana Gover)	A risk adjustment is now expected to be incorporated into the RFP.
To accommodate this need, a "risk pool" or "risk corridors" approach can be taken. The former would provide a pool of funds that would be drawn from and added to the capitation payment to meet outstanding unpaid claims. The latter would create specially designed pools that would adjust payment based on estimated services and supports used by enrollees based on their disability functional needs and related demographics. (Dana Gover)	A risk adjustment is now expected to be incorporated into the RFP.
Payment rates should initially be based on at least 2-3 years of the most recent Medicaid (and, as appropriate Medicare) claims data so payments account adequately for marketplace realities and are not artificially decreased to achieve savings. Therefore, Idaho Medicaid budgets should not be cut prematurely on the basis of "anticipated" savings. Experience applied to higher risk populations under such programs is first needed before savings can be determined as definitive. Moreover, savings that are achieved should remain at the disposal of the state's Medicaid program and reinvested in needed services and supports and improved care access, quality, coordination and efficiency. (Dana Gover)	Section E(ii) indicates that 36 months of data will be reviewed. Savings because of improved care coordination are an expected component of the program, but all savings must be shared between Medicare and Medicaid.
Covered services should include professional assessments of beneficiaries' needs for technology, as well as set-up, maintenance and user training. Managed care should also remain open to innovations in technologies that have the capacity to improve care quality and achieve short- and long-term cost savings. (Dana Gover)	In Section C(iii), the health plan is encouraged to offer additional services beyond Medicaid and Medicare services (which are already required).
8. The plan must include the provision of transportation and how the managed care entity will address the concern for those with limited transportation options. Idaho is a rural state, what happens if network providers in close proximity to the person are not available? Is there allowance for transportation costs? (Dana Gover)	Yes - Table A's service list specifically includes medical transportation. It also includes waiver services, which allow for non-medical transportation. The plans must offer these services and meet network adequacy requirements.
Critical Recommendations In particular, we urge Idaho to include the following four critical recommendations in the demonstration proposal submitted to CMS: 1. A plan to implement specific quality control measures for participating plans and specific triggers to signal the need for corrective action when quality thresholds are unmet. (AARP)	Quality measures are included in F(ii) and will be tied to reimbursement. Quality measures will be added and refined in the RFP.
2. A plan to create an oversight committee or task force independent of the Medical Care Advisory Council to monitor the demonstration with the ability to ensure that needed modifications and adjustments can be made during the demonstration timeframe. (AARP)	The MCAC and the PAO (a MCAC sub-committee) are currently the groups involved in monitoring the demonstration. A requirement has been added to Section D(i) that the health plan maintain an advisory committee which will include participants, participants' representatives, and providers.
3. A plan to reinvest financial savings realized through the demonstration program to improve access to and quality of home and community based-care services on a larger scale. (AARP)	The extent of savings are unknown as of yet, and many factors may be involved in determining what happens to savings.
4. Start with a regional pilot program in 2014 or implement the plan in stages. (AARP)	Feasibility of a statewide program will continue to be assessed.
Therefore, we urge Idaho to revise its proposal to: Require health plans participating in the demonstration either (1) to become a Medicare Part D plan subject to all of the Part D requirements or (2) to contract with the patients' Part D plan; (PhRMA)	CMS will drive the standards in the RFP for Medicare coverage.
Ensure that participating health plans offer the same level of access to medicines covered through Medicare Part B as is offered by Medicare Advantage plans and in Fee-For-Service Medicare; (PhRMA)	CMS will drive the standards in the RFP for Medicare coverage.
Significantly reduce planned enrollment in the demonstration to avoid destabilizing Part D for non-dual beneficiaries and risking significant disruptions of care for beneficiaries in Idaho, as well as to be consistent with the experimental nature of this initiative and allow for appropriate evaluation; (PhRMA)	The proposal takes an approach of enrolling all full dual eligibles (Section A). It is important to ensure coordinated care for dual eligible individuals. Further, there is a relatively small number of dual eligible individuals statewide, and having an adequate number of enrollees is important to the success of the program.
Protect beneficiary choice and avoid disruptions in care during this demonstration by exempting from passive enrollment in the demonstration all beneficiaries who have made an affirmative choice to enroll in Medicare Advantage or Special Needs Plans, or have affirmatively chosen a Part D plan; and (PhRMA)	The proposal takes an approach of enrolling all full dual eligibles (Section A). It is important to ensure coordinated care for dual eligible individuals. Further, there is a relatively small number of dual eligible individuals statewide, and having an adequate number of enrollees is important to the success of the program.
Protect continuity of care by establishing a transition period of at least six months during which beneficiaries can access their current providers and maintain their current prescriptions. (PhRMA)	Section D(ii) requires MCO to consider continuity of care in developing network thereby taking transitions (if applicable) into account. Outreach efforts to keep all parties well-informed will be ongoing as preparations for January 1, 2014 implementation continue.
Eliminate the requirement for all licensed clinical providers to be employed by an agency designated as a Mental Health Clinic. This reduces a Medicaid client's access to quality care by limiting the number of licensed clinical providers willing to participate in Medicaid because the already low reimbursement rates are further reduced by the employing agency's percentage. Given their advanced education and training, doctoral-level clinical providers, in particular, should not be mandated to be employed by a clinic. Consequently, most determine it is not cost effective to do this work. Also, it prevents many clinical providers, who are willing to dedicate a small percentage of their practice time to Medicaid clients, from being able to because they are not employed by a clinic. (IPA)	The program will ultimately align with the structure of the behavioral health managed care plan, which is still under development. The managed care entities, in their responses to the behavioral health RFP, are free to propose a design that either requires or does not require a clinical provider to be employed by an agency.
Reduce the steps to providing clients with appropriate and timely referrals. Just to get a referral to a psychologist for an evaluation under the current system, a client must: 1) get a referral to Healthy Connections from their primary care provider; 2) see their Healthy Connections medical provider; 3) see the medical director of the mental health clinic; and 4) participate in a Comprehensive Diagnostic Assessment. The psychological evaluation determines an accurate diagnosis to qualify the client for needed services. There are too many hoops for clients to jump through to get to a psychologist for appropriate services; many aren't willing and some just aren't "able" to make it through all these steps. For Medicaid, there are unnecessary expenses accrued by these issues, as people who could have been helped before a crisis, fall through the cracks and ultimately end up costing the system or the State even more. This process also results in more post-service work for the psychologist, which again cuts into the already limited pay; another reason many find it lacking cost-effectiveness for their practices. (IPA)	Behavioral health rules will ultimately align with the behavioral health managed care plan, which is still under development. The managed care entities, in their responses to the behavioral health RFP, are free to propose a design that they view to be optimal.

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Eliminate the requirement that MDs must sign off on treatment plans prepared by psychologists. In the current Medicaid system, psychologists, who are all doctoral-level providers already licensed by the State of Idaho to diagnose and treat "independently," must have the medical director of the clinic approve their treatment plans. This is an unnecessary form of supervision that further slows treatment. In addition, the psychologist has to pay the M.D. for this unwarranted oversight, which further reduces the already low reimbursement for the psychologist's work. If the goal is to integrate care, there are other ways to accomplish that. (IPA)	Behavioral health rules will ultimately align with the behavioral health managed care plan, which is still under development. The managed care entities, in their responses to the behavioral health RFP, are free to propose a design that they view to be optimal.
The Health Home Model discussed in the Demonstration Proposal sounds like a good concept but, realistically, the likelihood of finding a medical home with all needed services in a rural area is slim. This limitation may very well result in the need for significant travel by enrollees to obtain necessary services. For many, that is not a viable option. The model also indicated enrollees need to be able to self-direct care, something that is not available to much degree in the current Mental Health Clinic Model of Medicaid. We suggest building flexibility into the system by allowing for telehealth services, when necessary and appropriate. Also, if all medical home providers are required to be located in the same facility, it would be important to provide other options for rural communities, as mental health clients may be reluctant to come for treatment if they are likely to run into their friends and neighbors who are seeking medical treatment in the same building. (IPA)	The health home model is included in the proposal, and it will be refined in the RFP. Telepsychiatry, though not specifically mentioned in the proposal, is a state plan service that will be available. The proposal does not include a requirement that all members of the care management team be located in the same facility.
Make certain psychologists are considered primary care providers as they are under Medicare. Including psychologists serves to increase the size of the network, decrease wait lists, decrease the number of psychiatric and other hospitalizations, decrease medical costs in general, and streamline mental health treatment. (IPA)	Psychologists can be on the care management team and could do care coordination if they choose, so long as they remain in compliance with health home criteria.
Include psychologists as leaders for "care management teams" for enrollees needing mental/behavioral health services. Since psychologists are the most highly-trained specialists in the mental health field, their knowledge and leadership in making recommendations and direct referrals to the appropriate mental health providers would be beneficial. (IPA)	A reference stating that mental health providers can potentially be on the care management team was added to Section C(ii)
Don't restrict the size of the network. In addition, psychologists often specialize in certain areas of treatment. A client's access to the "right" provider can be more effective and less costly in the long run. Also, this will help "Dual Eligibles," who already may be receiving psychotherapy and/or evaluation services from psychologists, continue in their current treatment. (IPA)	Health plans must meet rigorous network adequacy requirements. The State does not have any plans to limit the network size in the RFP.