

Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles

Stakeholder Update
March 19, 2013

Statement of Initiative

- **The Centers for Medicare & Medicaid Services (CMS) and the Idaho Department of Health and Welfare (IDHW), Division of Medicaid will establish a Federal-State partnership to implement this Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”).**
- **The Federal-State partnership will include a three-way contract with participating health plans (Health Plans) to provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s).**

Statement of Initiative

- **The Demonstration will begin on March 1, 2014 and will continue until December 31, 2016.**
- **The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care and reduce costs for both IDHW and the Federal government.**

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **Target Population**
 - All full benefit Medicare-Medicaid enrollees age 21 and older
- **Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide**
 - 22,548 – as of July 2012
- **Geographic Service Area**
 - Statewide

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **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.
- **Financing Model**
 - Full Capitation
- **Proposed Implementation Date(s)**
 - March 1, 2014

	Dual Eligibles	Dual Eligibles Receiving Long Term Support Services (LTSS) in Institutional Settings			Individuals receiving LTSS in Home and Community Based Service Settings			Individuals not Receiving LTSS Services
		ICF/ID	SNF	ICF/ID + SNF	A&D Waiver	DD Waiver	Total	
Total	22,548	234	2,725	2,959	6,659	1,494	8,153	11,436
Individuals age 65+	10,171	32	2,302	2,334	4,084	95	4,179	3,658
Individuals ages 21 -65	12,377	202	423	625	2,575	1,399	3,974	7,778
Individuals with serious mental illness (SMI)	2,268	13	193	206	701	83	784	1,278
Individuals with SMI, age 65+	354	2	127	129	176	2	178	47
Individuals with SMI, under age 65	1,918	11	66	77	525	81	606	1,235

Health Plan Submission Requirements

- A Demonstration-specific application, which includes, among other items,
 - Demonstrating a network adequate to provide enrollees with timely and reliable access to providers and pharmacies for Medicare drug and medical benefits;
 - A model of care that meets Medicare, Medicaid, and Demonstration-specific requirements;
 - A formulary that **meets** Part D requirements;
 - A medication therapy management program (MTMP) that meets Part D requirements; and
 - A plan benefit package (PBP) that integrates Medicare, Medicaid, and Demonstration-specific benefits.

Idaho Health Plan Submissions

- **2014 Notice of Intent to Apply (NOIA) and Application Information for Medicare-Medicaid Plans**
 - 11 interested organizations submitted NOIA to participate in the capitated Financial Alignment demonstration beginning in 2014.
- **Two plans submitted the Model of Care (MOC)**

Health Plan Selection

- IDHW, in consultation with CMS, will issue a Request for Proposals (RFP) that includes IDHW requirements to become a Health Plan under this Demonstration.
- IDHW and CMS will engage in complementary selection processes that will take into account previous performance in Medicare and Medicaid, and ensure that bidders have met CMS' requirements.
- Applicants will be required to meet the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Demonstration application to CMS, and adherence to any annual contract renewal requirements and guidance updates.

Plan Selection Process Timeline

Key Timeline Step	Target Dates
CMS release HPMS Capitated Financial Alignment Demonstration Application module	January 10, 2013
CMS and State continue in-depth policy discussions to inform MOU development	Winter 2013
Plans submit applications via HPMS	February 21, 2013
MOU Signed	May 1, 2013
State releases RFP to interested organizations	May 1, 2013
Medication Therapy Management Program (MTMP) submission deadline	May 6, 2013
Plans submit base formularies	NLT May 31, 2013
Rates developed and finalized	Spring 2013
Plans submit integrated PBPs to CMS	June 3, 2013
Plans submit supplemental formulary files, including the Additional Demonstration Drug (ADD) file, in HPMS	June 7, 2013
Plans Selected by State	August 1, 2013
Contract development (CMS and the State)	August - November 2013
Readiness Reviews	August - November 2013
Contract shared with Plans and the State	November 15, 2013
State and Plan Sign contract returned to CMS	December 6, 2013
MMCO sign-off to CMS system on 2013 contract	December 13, 2013
Plan (and State Plan-specific) Marketing begins	February 1, 2014
Opt-in period begins	March 1, 2014
60-day beneficiary notice sent (State)	February 1, 2014
30-day beneficiary notice sent	March 1, 2014
Passive Enrollment takes effect	April 1, 2014

Enrollment

- **The Demonstration requires beneficiaries have a choice of at least two Plans in a region when there is mandatory Medicaid Managed Care enrollment.**
- **If there are not two Plans in a particular region, IDHW may apply for rural exemption.**

Enrollment

- Eligible individuals will be notified of their right to select among contracted Health Plans no fewer than 60 days prior to the effective date of enrollment.
- If no active choice has been made, enrollment into a Health Plan will be conducted using a seamless, passive enrollment process.
- Beneficiaries will be able to enroll or disenroll/change Health Plans at any time.
- Disenrollment from the Demonstration means that an individual chooses to receive Medicare services either through the traditional Medicare fee-for-service system or through a Medicare Advantage plan rather than through a Health Plan participating in the Demonstration that covers and coordinates all Medicare and Medicaid services.

Enrollment

- Individuals who disenroll from the Demonstration will remain enrolled in a Medicaid Managed Care Health Plan.
 - These individuals will remain with the same Health Plan for Medicaid Managed Care benefits unless they affirmatively choose to transfer to a different Health Plan for those benefits.
- Prior to the effective date of their enrollment, all Medicare-Medicaid eligible individuals will be notified of the right to opt-out of Medicare Managed Care, and will receive sufficient information with which to do so.
- Disenrollment from Health Plans and transfers between Health Plans will be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month.

Enrollment

- **Uniform Enrollment/Disenrollment Documents:**
 - CMS and IDHW will develop uniform enrollment and disenrollment forms and other documents.
- **Outreach and Education:**
 - Health Plan outreach and marketing materials will be subject to a single set of marketing rules by CMS and IDHW.
- **Single Identification Card:**
 - CMS and IDHW will work with Health Plans to develop a single identification card that can be used to access all care needs.

State Opt-In Enrollment Period and Phased-In Enrollment Approach

Enrollment will be phased in using IDHW's three geographical hubs (Southwest, East, and North).

- Opt-in enrollment in the Southwest hub begins on March 1, 2014.
- All Participants in the Southwest hub who have not opted-in before April 1, 2014 will be enrolled on that date.
- All Participants in the East hub will be enrolled effective June 1, 2014.
- All Participants in the North hub will be enrolled effective August 1, 2014.

The counties in each IDHW hub are as follows:

- Southwest hub: Adams, Canyon, Gem, Owyhee, Payette, Washington, Ada, Boise, Elmore and Valley counties
- East hub: Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, Twin Falls, Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, Power, Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton counties
- North hub: Benewah, Bonner, Boundary, Kootenai, Shoshone, Clearwater, Idaho, Latah, Lewis, and Nez Pece counties

Health Plan Service Capacity

- Health Plans must demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees.
- Medicare covered benefits will be provided in accordance with 42 CFR §422 and 42 CFR §423 et seq.
- Medicaid covered benefits will be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1915(b) and/or 1915(c) waivers and in accordance with the requirements specified in the state RFP and MOU.

Health Plan Service Capacity

- Health Plans are encouraged to offer supplemental benefits that exceed those currently covered by either Medicare or Medicaid.
- CMS, IDHW, and Health Plans will ensure that beneficiaries have access to an adequate network of medical, pharmacy, behavioral health, and Long Term Services and Supports (LTSS) providers that are appropriate and capable of addressing the needs of this diverse population.

Network Adequacy

- **State Medicaid standards will be utilized for LTSS or for other services for which Medicaid is primary.**
- **Medicare standards will be utilized for pharmacy benefits and for other services for which Medicare is primary.**
- **Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, will be subject the more stringent of the applicable Medicare and Medicaid standards.**

Network Adequacy

- Health Plans must do the following, at a minimum, to meet the Medicaid network adequacy standards for Medicaid services:
 - Offer an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.
 - Maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
 - Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
- IDHW also requires that Health Plans provide and arrange for timely access to all medically-necessary services covered by Medicaid.

Network Adequacy

- CMS and IDHW will monitor access to services through survey, utilization, and complaints data to assess needs to Health Plan network corrective actions.
- CMS and IDHW will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that Health Plans initiate further network expansion over the course of the Demonstration.
- Where this standard is not achievable, the Health Plan will develop a plan for moving toward achieving this standard.
- Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

Health Plan Marketing, Outreach, and Education Activity

- Health Plans will be subject to rules governing their marketing and Enrollee communications
 - These are specified under section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

Health Plan Marketing, Outreach, and Education Activity

- Health Plans must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and IDHW require to be prospectively reviewed.
- Health Plans may begin marketing activity no earlier than 90 days prior to the effective date of enrollment.
- CMS and IDHW will work together to educate individuals about their Demonstration options.
 - Enrollees will be educated on all potential Plan choices through a variety of mechanisms.
 - Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, and limited English proficiency.

Health Plan Marketing, Outreach, and Education Activity

At a minimum, Health Plans will provide current and prospective Enrollees the following materials:

- An Evidence of Coverage (EOC) document that includes information about all State-covered and Plan-covered supplemental benefits, in addition to the required Medicare benefits information.
- An Annual Notice of Change (ANOC) summarizing all major changes to the Plan's covered benefits from one contract year to the next, starting in the second calendar year of the Demonstration.
- A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the Plan, as well as the benefits offered under the Plan, including premiums, cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. Health Plans will use a Demonstration-specific SB.

Health Plan Marketing, Outreach, and Education Activity

At a minimum, Health Plans will provide current and prospective Enrollees the following materials:

- A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and supplemental benefits.
- A comprehensive integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as Plan-covered supplemental benefits.
- A single identification (ID) card for accessing all covered services under the Plan.
- All Part D required notices.

Health Plan Marketing, Outreach, and Education Activity

- **42 CFR §423.120(b)(5) requires that Health Plans provide at least 60 days advance notice regarding Part D formulary changes also applies to Health Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as supplemental benefits.**
- **Health Plans must submit all marketing and Member communication materials via the CMS Health Plan Management System Marketing Module.**

Health Plan Marketing, Outreach, and Education Activity

- Any marketing materials distributed by the Health Plan must be distributed to the entire services area in which the Health Plan operates under the contract.
- Health Plans must comply with the information requirements of § 438.10 to ensure that, before enrolling, the beneficiary receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

Health Plan Marketing, Outreach, and Education Activity

- The Health Plan will not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- The Health Plan will not directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities.
- IDHW will share demographic information with the Health Plan to promote effective marketing and enrollment.

Health Plan Marketing, Outreach, and Education Activity

- None of Health Plan's enrollment agreements may suggest that a person must enroll in order to obtain benefits or in order not to lose benefits.
- None of the Health Plan's marketing materials may state or suggest that the Health Plan's product is endorsed by CMS, State government or similar entities.

Questions?

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Demonstration Proposal Feedback

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