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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

*Idaho Division of Medicaid*

*Demonstration Proposal to Integrate Care for Dual  
Eligibles*

*Draft for Public Comment*

*April 2012*

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DRAFT

59 The State of Idaho is posting this proposal for a 30-day public comment period from April 13,  
60 2012 to May 12, 2012 before submitting the proposal to the Centers for Medicare and Medicaid  
61 Services (CMS) by May 31, 2012 to CMS. Please send comments to  
62 [LTCManagedCare@dhw.idaho.gov](mailto:LTCManagedCare@dhw.idaho.gov) no later than 5:00 pm on May 12, 2012 or respond to the  
63 survey at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov> . This proposal will also be  
64 discussed in a statewide videoconference on April 17<sup>th</sup>, 2012 from 1 p.m. – 3 p.m. Please  
65 register for the videoconference at: <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.  
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## 68 *A. Executive Summary*

69

70 The State of Idaho intends to participate in the Demonstration to Integrate Care for Dual Eligible  
71 Individuals. The goal of this initiative is to integrate and coordinate care for all full-benefit  
72 Medicare-Medicaid enrollees (“dual eligibles”) living anywhere in the State, in order to improve  
73 their health and quality of life. Idaho Medicaid’s participation reflects a desire to improve the  
74 quality and cost-effectiveness of care for this vulnerable population. Further, this proposal  
75 responds to the Idaho Legislature’s direction in House Bill 260 to develop a managed care plan  
76 for dual eligibles that will result in an accountable care system with improved health outcomes.  
77

78 Dual eligibles often have difficulty navigating the complex Medicare and Medicaid systems to  
79 properly address their extensive medical needs, frequent care transitions, and interactions with  
80 multiple providers and provider types in various settings. Many complications arise because  
81 Medicare and Medicaid were not designed with an intention to serve people in both programs in  
82 a coordinated manner. As a result, there are different Medicare and Medicaid rules and  
83 processes for enrollment, benefits, appeals, administration, marketing, financing, and more. This  
84 current state of misalignment means that dual eligibles can greatly benefit from an approach  
85 under which one entity coordinates their full range of interactions with the health care system.  
86

87 Consequently, Idaho intends to enter into a three-way, three-year contract with CMS and health  
88 plans (managed care organizations) to provide integrated, comprehensive, seamless coverage to  
89 dual eligibles. The contracts will require the health plans to ensure that all necessary Medicaid  
90 and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-  
91 term supports and services) are provided, coordinated, and managed. The beneficiary will have  
92 an integrated set of benefits, one process for resolving disputes, and one entity responsible for  
93 coordinating the provision of high-quality, efficient care. For those individuals who qualify for a  
94 health home under Section C(e) of this proposal, health plans will contract directly with the  
95 health homes, which will continue to provide care management and coordination.  
96

97 The contracts will build in financial incentives which align the interests of the health plans and  
98 the beneficiaries. Health plans will maximize their success only by offering excellent care to  
99 beneficiaries. Payments to health plans will be blended capitation payments based on an  
100 actuarial analysis of historical costs and projected costs for duals’ Medicare and Medicaid  
101 services. Payments will not be increased or decreased based on actual expenditures during this  
102 demonstration. Payments will be adjusted, however, based on health plan performance with  
103 respect to quality measures.  
104

105 Dual eligibles are currently able to opt into a Medicare-Medicaid Coordinated Plan (MMCP)  
 106 made available under the authority of §1937 of the Social Security Act. This program covers  
 107 and coordinates Medicare and many Medicaid services, and it will continue unchanged through  
 108 the end of 2013. Starting on January 1, 2014, Idaho will replace the current MMCP with the new  
 109 coordinated program. The new program will utilize mandatory enrollment into health plans  
 110 under concurrent §1915(b)/ §1915(c) Social Security Act authority for Medicaid plan benefits,  
 111 and passive enrollment with an opt-out provision for Medicare benefits. This has been  
 112 determined to be the most effective way to ensure quality, coordinated care for all full dual  
 113 eligibles in Idaho. Beneficiary choices and protections are a priority, as people will have the  
 114 right to choose from at least two plans, change plans, self-direct care, choose from available  
 115 providers within the plan’s network, appeal health plan decisions, opt out of the Medicare  
 116 component of the plan, etc. Additionally, stakeholder involvement and input has been, and will  
 117 continue to be, a vital component of the development of the program (see Section D).  
 118  
 119

120 **TABLE A: Summary of the Idaho Initiative to Integrate Care for Dual Eligibles**  
 121

<b>Target Population</b>	All full benefit Medicare-Medicaid enrollees
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	17,219 – as of June 2011
<b>Total Number of Beneficiaries Eligible for Demonstration</b>	17,219 – as of June 2011
<b>Geographic Service Area</b>	Statewide
<b>Summary of Covered Medicaid Benefits through Coordinated Plans - 2014</b>	<p>All Medicaid services will be available to qualifying participants including State Plan, Basic Plan, Enhanced Plan and HCBS waiver services based on their needs.</p> <p><b>HOSPITAL SERVICES:</b>          Inpatient          Outpatient</p> <p><b>LONG-TERM CARE SERVICES:</b>          Nursing Facilities          Personal Care Services          Home Health          Aged and Disabled Waiver Services          Developmental Disability Waiver Services</p> <p><b>PHARMACY SERVICES:</b>          Prescription Drugs; Medicare-covered Drugs          Medicare Part D Excluded Drugs Covered by Medicaid</p> <p><b>MEDICAL SERVICES:</b>          Physician Services          Other Practitioners          Lab &amp; Radiological Services          Federally Qualified Health Centers</p>

	<p>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</p> <p><b>DENTAL SERVICES</b></p> <p><b>DEVELOPMENTAL DISABILITY SERVICES</b>  DD Waiver Services (mentioned above)  ICF/ID Services  Dev. Disability Agency Services</p> <p><b>VISION SERVICES</b></p> <p><b>MENTAL HEALTH SERVICES</b>  Inpatient Psychiatric Services  Outpatient Mental Health Services</p> <p><b>OTHER SERVICES</b>  Primary care case management  Indian Health Services  Medical Transportation</p>
<p><b>Summary of Stakeholder Engagement/Input</b></p>	<p>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 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  2012 - Quarterly Personal Assistance Oversight (PAO) committee meetings, quarterly Medical Care Advisory</p>

	Committee (MCAC) meetings, and Nursing Facility Prospective Payment System meetings
<b>Financing Model</b>	Full Capitation
<b>Proposed Implementation Date(s)</b>	January 1, 2014

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***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.<sup>1</sup> 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.<sup>2</sup> These expenditure levels are likely to change, as only some Medicaid services are currently covered. As of June 2011, only 1,031 of 17,219 dual eligibles, or 6% 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.

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<sup>1</sup> “Integrating Care for Medicare-Medicaid Enrollees.” Centers for Medicare and Medicaid Services. <http://www.cms.gov/medicare-medicaid-coordination/downloads/MedicareMedicaidCoordinationOfficeGeneralPresentation.pdf>.  
<sup>2</sup> <http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCareManagedCare/tabid/1910/Default.aspx>

160 Benchmarks are the preferred plans because they offer more benefits designed to meet the health  
161 needs of the individual. Most applicants will have a choice of the standard plan or the Basic Plan.  
162 Only individuals who have disabilities or special needs can choose between the standard plan  
163 and the enhanced plan. Plan changes can be made after enrollment based on changes in health  
164 status. The Medicare/Medicaid plan choice is designed specifically for individuals who have  
165 both Medicare and Medicaid coverage.

166  
167 Idaho Medicaid does offer a primary care case management program, Healthy Connections, to  
168 Medicaid participants. Healthy Connections is a program by which health care services are  
169 provided through a single point of entry into the system, the person's primary care provider  
170 (PCP). The PCP, in addition to providing care, makes referrals to other providers when care is  
171 needed that he or she cannot provide. However, Healthy Connections only applies to Medicaid  
172 services. It does not help with coordination of Medicare services, and it does not coordinate  
173 services between Medicare and Medicaid. It does not resolve the misalignment between  
174 Medicare and Medicaid, or any of problems associated with that misalignment. It does,  
175 however, help to provide improved management of care for dual eligibles' Medicaid services.

176  
177 Dual eligibles in the MMCP and Healthy Connections programs will not see a change in their  
178 programs through the end of 2013. Starting in 2014, however, the coordinated care program will  
179 address the low MMCP participation by using a mandatory enrollment process into the new,  
180 coordinated health plans, under concurrent §1915(b)/§1915(c) Social Security Act authority.  
181 Duals currently in the MMCP will see improved, comprehensive care coordination in the new  
182 program. Dual eligibles currently in Healthy Connections and duals in neither the MMCP nor  
183 Healthy Connections will have their Medicare and Medicaid services coordinated for the first  
184 time.

185  
186 Also for the first time, Idaho Medicaid will offer the full spectrum of Medicare and Medicaid  
187 benefits through the new, coordinated health plans. The current MMCP does not cover certain  
188 Medicaid waiver services, including long term care services, personal care services, psychosocial  
189 rehabilitation, and developmental disability services. This leads to service fragmentation even  
190 for participants in the MMCP, as some of their Medicaid services are still available outside the  
191 plans provisions on a fee-for-service basis. This problem will be eliminated in 2014 because the  
192 State will require participating health plans to cover and coordinate all Medicaid and Medicare  
193 services. Participants will not necessarily receive any new benefits which are not already  
194 available to them, but the coordination of these benefits by one entity will enhance efficiency and  
195 improve the quality of care. Further, the State will encourage health plans to use their option to  
196 include additional benefits as a way to further improve quality and increase enrollment.

197  
198 The coordination of services will lead to better health outcomes, greater cost-effectiveness, and  
199 care being provided in the most appropriate setting. Currently, there is a potential incentive for  
200 either Medicaid or Medicare to reduce expenditures by sending beneficiaries to providers and/or  
201 settings that the other is responsible for payment. Medicare generally is responsible for most  
202 primary and acute care services while Medicaid is responsible for most long term care services  
203 and supports. For example, Medicare could reduce its costs by shifting care to nursing facilities,  
204 where Medicaid is typically the payer. Likewise, Medicaid could reduce its costs by shifting  
205 care to hospital settings, where Medicare is usually the payer. Unfortunately, this type of

206 incentive structure can increase aggregate costs, create confusion for beneficiaries, and even  
207 harm people’s health.

208  
209 By creating a coordinated system of care, cost-shifting will be reduced, because the health plans  
210 will be responsible for managing all benefits. Health plans will receive the same reimbursement  
211 regardless of the setting where care is provided. Medicare and Medicaid will be responsible for  
212 the same per member per month payments regardless of where services are delivered. Health  
213 plan performance with respect to quality measures will impact what the health plans are paid, in  
214 order to ensure that decisions are based on what is best for the person. In the new system,  
215 neither the health plan, nor Medicare, nor Medicaid will benefit financially from shifting care to  
216 a setting which is not beneficial to the person.

217  
218 As one example of how the new system can benefit all parties, consider individuals residing in  
219 more restrictive settings than necessary or desired. Some people live in a nursing facility (NF) or  
220 an intermediate care facility for the intellectually disabled (ICF/ID) even though they could  
221 thrive in a community setting. These individuals can benefit greatly if they transition from  
222 institutional care into the community. Benefits for many parties from such a transition would be  
223 substantial. The individual could have greater freedom and a higher quality of life due to being  
224 in a less restrictive setting. The State could ensure compliance with the Americans with  
225 Disabilities Act, as interpreted by the Supreme Court’s decision in the *Olmstead* case.<sup>3</sup> The  
226 health plan could realize substantial savings, as care in the community is significantly less costly  
227 than care in institutions. Medicare and Medicaid would also share in any savings, regardless of  
228 which program the benefits would ordinarily have been obtained through.

229  
230 All individuals with full eligibility for Medicaid and Medicare who live in the State of Idaho will  
231 be eligible to participate in the proposed demonstration. This means that participants must be at  
232 least 18 years old, because that is the minimum age requirement to be eligible for Medicare. The  
233 population is classified in more detail in *Table B*, below. Individuals who are partial dual  
234 eligibles (i.e. do not receive Medicaid health care services but do receive assistance from  
235 Medicaid in paying Medicare premiums) are NOT eligible for this proposed demonstration.

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<sup>3</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999)

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**Table B: Dual Eligible Classifications**

	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		
<b>Total</b>	<b>17,219</b>	<b>191</b>	<b>1,283</b>	<b>1,474</b>	<b>5,684</b>	<b>10,061</b>
<b>Individuals age 65+</b>	<b>6,971</b>	<b>24</b>	<b>1,032</b>	<b>1,056</b>	<b>2,583</b>	<b>3,332</b>
<b>Individuals ages 18-65</b>	<b>10,248</b>	<b>167</b>	<b>251</b>	<b>418</b>	<b>3,101</b>	<b>6,729</b>
<b>Individuals with serious mental illness (SMI)</b>	<b>1,971</b>	<b>13</b>	<b>105</b>	<b>118</b>	<b>626</b>	<b>1,227</b>
<b>Individuals with SMI, age 65+</b>	<b>269</b>	<b>2</b>	<b>70</b>	<b>72</b>	<b>128</b>	<b>69</b>
<b>Individuals with SMI, under age 65</b>	<b>1,702</b>	<b>11</b>	<b>35</b>	<b>46</b>	<b>498</b>	<b>1,158</b>

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**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. In 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.

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

- 264                   ○ Available medical and supportive service providers:
  - 265                   ▪ Managed care providers will be required to ensure the availability of
  - 266                   appropriate service providers who are proficient in meeting the needs of the
  - 267                   dual eligible population, in accordance with Medicaid and Medicare
  - 268                   requirements. In the State of Idaho, the following resources exist:

269  
270  
271                   **Statewide as of March 2010**

272                   • Hospitals:	51
273                   • Certified Family Homes:	2,152
274                   • Skilled Nursing Facilities:	79
275                   • Residential Care/Assisted Living Facilities:	290
276                   • Rural Health Clinics	At least 46
277                   • Federally Qualified Health Centers	At least 38
278                   • Tribal Clinics	At least 5
279                   • Medicaid Providers (Excluding Dentists)	3,525
280                   • Dentists Accepting Medicaid	680
281                   • Personal Assistance Agencies	259

282  
283  
284                   **ii. Proposed benefit design, alignment of Medicare and Medicaid services, and**  
285                   **responsibility for managing services.**

286  
287                   CMS, the State, and the health plans will agree to a three-way contract. The health plans will  
288                   receive capitated payments. The health plans will make arrangements to provide for coverage of  
289                   the full spectrum of medically necessary Medicare and Medicaid services, including Medicaid  
290                   waiver services (see Table A). A single, cohesive set of benefits will be made available. One  
291                   benefit card will be used to access services, rather than multiple cards. A single process will be  
292                   in place to obtain the care that is needed. A single health plan will answer all questions  
293                   regarding care. A single health plan will handle all initial appeals. Medicare and Medicaid  
294                   services, and the associated policies and procedures, will be aligned in one health plan even  
295                   though the ability to receive those benefits originates in two distinct sources. The participant  
296                   should not notice practical differences based on whether a service is available through Medicare  
297                   or Medicaid.

298  
299                   The health plan will provide for service coordination by contracting with a care management  
300                   team that will implement principles associated with the health home model of care. The care  
301                   management team will consist of a minimum of the participant, a care coordinator, and a primary

302 care physician (PCP). The PCP is the anchor of the team, but additional team  
303 members/providers will be added as needed in order to effectively coordinate and provide the  
304 full range of Medicare and Medicaid services through a multidisciplinary approach. The  
305 participant should play as active a role with the team as possible.  
306

307 The broader team could grow to include a pharmacist, advocate, family member, or HCBS  
308 providers. The care management team's health home approach means that it will coordinate care  
309 with all providers and facilities, assist with discharge planning, manage care for those with  
310 complex medical needs, and facilitate transitions between providers and between institutional  
311 and community settings. The team will emphasize preventive care, and it will help ensure that  
312 principles of person-centered care and evidence-based practices are followed as a matter of  
313 standard practice.  
314

315 More specifically, the care team must:  
316

- 317 1. Work with the participant/family to develop a comprehensive, written plan of care that  
318 includes the following, at minimum:
  - 319 a. A summary of current health status and health history;
  - 320 b. A person-centered approach that includes the participant's goals, status of goals,  
321 barriers to goals, and specific recommendations on how to achieve goals;
  - 322 c. List of all diagnoses and medications;
  - 323 d. List of all health problems and concerns:
    - 324 i. A plan to correct or manage each acute and chronic condition, and prevent  
325 potential problems that are likely to develop without intervention;
    - 326 ii. Self-management information and training whenever appropriate;
  - 327 e. List of acute and chronic medical, behavioral health, long-term care, and social  
328 service needs, and supports/services already in place;
  - 329 f. Treatment goals that are reviewed and updated with each relevant visit;
  - 330 g. Participant's role in increasing wellness, including practical ways the participant  
331 can improve health and quality of life; and
  - 332 h. Summary of the role of each member on the care team, and how the members of  
333 the care team will interact and collaborate through the course of the year.
- 334 2. Update the care plan on an ongoing basis as appointments occur, tests are completed,  
335 medications change, transitions are made; goals are added or completed, etc.
- 336 3. Provide comprehensive care coordination and management:
  - 337 a. Communicate with all providers on the care team about any health issues that  
338 could affect their care;
  - 339 b. Communicate with all facilities where the participant may live or receive care  
340 about any health issues that could affect their care;
  - 341 c. Make referrals to appropriate providers as needed;
  - 342 d. Collaborate with facilities on discharge planning to ensure the appropriate  
343 safeguards are in place after leaving the facility;
  - 344 e. Communicate with other providers regarding results of appointments;
  - 345 f. Ensure that participants are aware of their roles and the roles of various providers;  
346 and

- 347 g. Ensure that all providers and facilities are aware of and working towards the same  
348 goals.
- 349 4. Offer same-day appointments.
  - 350 5. Emphasize and implement principles of evidence-based practices, and offer/encourage  
351 preventive care.
  - 352 6. Connect the participant with community-based resources when appropriate.
  - 353 7. Attempt to schedule a minimum of one annual appointment with the PCP annually, even  
354 if there are no immediate health concerns.
  - 355 8. Provide timely clinical advice by phone during office hours.
  - 356 9. Offer communication options by phone and email.
  - 357 10. Counsel at least 50 percent of patients/families to adopt specific, healthy behaviors.
  - 358 11. Provide educational resources for at least 50 percent of patients/families to assist in self-  
359 management.

360 **iii. Service Availability**

362 From the participant perspective, no services will be modified, added, or removed. What will  
363 change is that all Medicaid and Medicare services will be obtained and coordinated through one  
364 health plan. Idaho Medicaid has a robust array of benefits available to dual eligible participants,  
365 and all current benefits will continue to be available through the new health plans. Depending on  
366 which eligibility criteria are met, participants may currently be enrolled in the Medicaid Basic  
367 Plan, Enhanced Plan, Home and Community Based (HCBS) Waivers, or MMCP. In 2014, the  
368 full spectrum of Medicaid benefits in these programs will be available through the new  
369 coordinated health plans. (Refer to Table A for a summary of Medicaid services the health plans  
370 will be required to offer.) For some of these services available through Medicaid, Medicare is  
371 currently the primary payer for dual eligibles. However, when the health plan covers all services  
372 in 2014, it will in effect become the sole payer for all services, regardless of whether Medicare or  
373 Medicaid would have ordinarily been responsible for payment. The State will encourage health  
374 plans to offer additional benefits not covered in the state plan as a means of enhancing quality  
375 and competing for higher levels of enrollment. However, federal regulations prohibit the costs  
376 for these additional services from being built into the capitation rate paid to the health plans.<sup>4</sup>  
377

378

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

380

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

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<sup>4</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services, *U.S. Code of Federal Regulations*, 42, sec. 438.6 (2002).

390 of services, and other areas to which the practice standards apply are consistent with the  
391 standards.

392

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

398

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

400

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

405

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

409

410 Two home and community based waivers, the Aged and Disabled waiver and the  
411 Developmentally Disabled waiver, offer services in addition to the Basic Plan services and  
412 Enhanced Plan services that waiver participants may also receive. These include a variety of  
413 home and community-based services which help people to live in the community and avoid  
414 institutionalization.

415

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

425

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

427

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

435

436 The proposed model builds upon many of the same principles used in the existing MMCP.  
437 However, the new model will be comprehensive, and it will include long term care services.  
438 Specifically, new services required in the health plans in 2014 will include nursing facility  
439 services, personal care services, mental health services, waiver services, medical transportation,  
440 and developmental disability services. Because the current MMCP plan has had relatively low  
441 participation rates (only 1,031 of 17,219 dual eligibles were enrolled as of June, 2011),  
442 additional outreach and educational efforts may be conducted to increase participation rates in  
443 the MMCP in 2013. In 2014, Idaho Medicaid will enroll all full dual eligibles into the health  
444 plans in order to ensure well-coordinated, high-quality care for Idaho's dual eligible individuals.

445  
446 *c. Existing specialty behavioral health plan:*  
447  
448

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

456  
457 Full dual eligibles who are enrolled in the mental health managed care program in 2013 will be  
458 transitioned out of that program and into a health plan for duals effective January 1, 2014. All  
459 health plans for duals will be required to offer the same mental health services provided in the  
460 mental health managed care program for all qualifying dual eligible participants. Full dual  
461 eligibles will receive all benefits, including mental health benefits, through the integrated health  
462 plans specifically created for duals. Health plans will be free to provide these benefits by  
463 contracting with the same managed care entity that provides mental health benefits for non-dual  
464 Medicaid participants, or they may provide for the same set of benefits through other means.

465  
466  
467 *d. Integrated programs via Medicare Advantage Special Need Plan (SNP):*  
468

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

480  
481 *e. Other CMS payment/delivery initiatives or demonstrations:*

482  
483 As mentioned earlier, all full dual eligibles will be linked to a primary care provider who will  
484 follow a health home approach. Idaho is also working to create a Medicaid State plan option to  
485 offer health homes for the following specific categories of individuals:

- 486  
487 1) A serious, persistent mental illness, or  
488 2) Diabetes and an additional condition, or  
489 3) Asthma and an additional condition.

490  
491 The exact implementation date is uncertain, but is believed to be in the second half of calendar  
492 year 2012. The new coordinated plans for dual eligibles will need to contract with the health  
493 homes to ensure that those benefits will be made available to all qualifying dual eligible  
494 individuals, as they will become required Medicaid State plan benefits.

495  
496 To qualify as a health home, specific requirements must be met. Although the details of the  
497 health home program have not yet been finalized, health homes are primary care practices which  
498 will provide comprehensive care management for the whole person. The health home model will  
499 provide care for an individual's physical condition, and it will also provide links to long-term  
500 community care services and supports, social services, and family services. The health home  
501 program and the coordinated care program should fit together well, because both share the  
502 provision of seamless, efficient care as an important goal. Further, the plans are required to  
503 contract with PCP's and care coordinators who will use health home principles for all  
504 participating dual eligibles who do not formally qualify for health home services under the State  
505 plan. The health home will receive Fee for Service payments from the health plan for services  
506 rendered. The health home will also receive a per member per month payment for the  
507 coordinating and managing the Medicaid services of individuals who qualify for health homes.

#### 508 509 D. Stakeholder Engagement and Beneficiary Protections

##### 510 511 i. Engagement of internal and external stakeholders

512  
513 Implementation of this proposal will rely on effective partnerships with participants, families,  
514 advocates, providers, health plans, etc. Success will largely be contingent upon engagement and  
515 the capacity of health care and service providers that support and care for Medicare-Medicaid  
516 enrollees in their communities. Stakeholder input has been welcomed and encouraged  
517 throughout the development process. Idaho Medicaid recognizes that developing a managed  
518 care program for dual eligible participants is a collaborative, Statewide effort involving  
519 participants, families, Medicaid staff, providers, health plans, community partners, and agencies.  
520 Medicaid continues to seek input and feedback from all interested parties. A summary of the  
521 history and status of stakeholder involvement follows:

522  
523 A website is available to facilitate communication with stakeholders at  
524 <http://www.MedicaidLTCManagedCare.dhw.idaho.gov> . Website features include a summary of  
525 the history and status of the initiative, a survey through which suggestions can be offered, a  
526 feedback form which takes suggestions and questions, a brief of the proposal, links to panelist

527 presentations at a Statewide stakeholder videoconference, information regarding upcoming  
528 events, and a number of helpful links.

529  
530 In addition to the website, other efforts have been and will continue to be made to work with  
531 broad groups of stakeholders. For instance, a Statewide videoconference was held with  
532 consumers, advocates, and providers on October 26, 2011. More than 50 people participated in  
533 the meeting, which was held at the Boise Medicaid State office and available by videoconference  
534 at six other sites throughout the State. Idaho Medicaid Long Term Care Bureau Chief Natalie  
535 Peterson provided background and information for the dual eligible managed care initiative.  
536 Following her presentation, a panel of six stakeholders presented their ideas and priorities for the  
537 design of a managed care system for dual eligible participants. Their PowerPoint presentations  
538 are available by clicking their names at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.  
539 Many expressed hope in the promise of a well-designed program, while recognizing some  
540 potential challenges.

541 Another Statewide videoconference will be held to discuss this proposal on April 17, 2012. The  
542 purpose is to gather feedback and suggestions, and make any needed changes before submitting  
543 the proposal to CMS. Further, stakeholders continue to have an opportunity to discuss issues for  
544 dual eligible individuals through the quarterly Personal Assistance Oversight (PAO) committee  
545 meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing  
546 Facility Prospective Payment System meetings.

547 A number of meetings have also been held with the potential health plans. An initial meeting  
548 was held on September 26, 2011, with five interested plans in attendance (Pacific Source, United  
549 Healthcare, Blue Cross of Idaho, Regence Blue Shield, and Sterling Plans). An overview of  
550 CMS's guidance on opportunities to align financing between Medicare and Medicaid to support  
551 improvements in quality and cost of care was given. This was followed by a discussion of the  
552 current MMCP, and feedback was provided on strengths and weaknesses of that program from  
553 the perspective of the health plans and Medicaid. There was a discussion that focused on  
554 barriers to enrollment in that program, strengths of the model and opportunities for improvement.  
555 Medicaid solicited and received input regarding the interest in offering a fully integrated model  
556 and the readiness of the health plans to offer such a model. Concerns, hopes and suggestions on  
557 how to make such a model a success were discussed. Plans expressed excitement about the  
558 opportunity to coordinate care. The importance of having one set of processes was mentioned,  
559 so that beneficiaries will not have to go to several places to obtain the information they need.  
560 One health plan indicated that it had completed a readiness review and had the core elements  
561 needed for the program in place already. There was recognition that the target implementation  
562 date of January 1, 2013 was an aggressive timeline. This feedback, along with similar feedback  
563 from other stakeholders, was significant in shaping the decision to move the target  
564 implementation date to January 1, 2014. Please refer to Attachment 1 for the meeting minutes.  
565 Monthly meetings with health plans began on December 2, 2011 and continue to be held. The  
566 next meeting is scheduled for May 10<sup>th</sup>, 2012.

567  
568 Idaho Medicaid has considered and incorporated feedback regarding the importance of self-  
569 direction and payment structures that encourage the proper utilization of care. A self-direction  
570 option must be offered by all participating health plans. Participants must be permitted to choose

571 and change their direct care staff. Further, health plans reimbursement will be tied to quality  
572 measures to ensure that appropriate care is provided. Feedback will be continue to be  
573 encouraged and considered throughout the demonstration. Additional comments have been  
574 offered regarding challenges of covering services for the developmentally disabled population in  
575 2014. For this reason, the State may consider a phased-in approach to including services for  
576 people who have developmental disabilities in the demonstration.

577  
578 A number of other managed care meetings have been held throughout the development of this  
579 proposal. Oregon and Utah presented their managed care experience to the Idaho Legislature on  
580 November 18, 2011, and several Medicaid representatives attended. A public forum on  
581 Medicaid managed care program for comprehensive medical services was held on December 13,  
582 2011, and a hospital panel, a physician panel, and a community health center panel presented  
583 their recommendations. Managed care presentations were given to Idaho Senate committee  
584 members on February 16, 2012 and to Idaho House committee members February 24th. The  
585 Nursing Home Prospective Payment System meeting with skilled nursing and intermediate care  
586 facility providers on February 23, 2012 also included a discussion regarding managed care for  
587 dual eligibles.

588  
589 Input from stakeholders will continue to be encouraged and facilitated as the initiative moves  
590 forward.

591  
592 ii. Description of beneficiary protections.

593  
594 The beneficiary will be afforded numerous protections. The following processes and protections  
595 will be in place for the beneficiaries:

- 596  
597 A. The plan must make a comprehensive enrollee handbook available to prospective  
598 enrollees upon request and actual enrollees upon enrollment. It shall be written in  
599 plain language and it shall be available in formats that are accessible and  
600 understandable for people with disabilities or limited English proficiency.
- 601 B. The beneficiary may choose which participating health plan to join.
- 602 C. The beneficiary may choose appropriate providers from within the plan's  
603 network.
- 604 D. At least two health plans will be available to choose from.
- 605 E. A beneficiary who is dissatisfied with the current health plan may disenroll from  
606 that plan and enroll in a new health plan, effective the first of any month, so long  
607 as Medicaid is notified and the change is requested fifteen (15) days in advance.
- 608 F. Beneficiaries must have an option to self-direct their care; they must be permitted  
609 to choose and change their direct care staff.
- 610 G. Beneficiaries may opt out of the plan for their Medicare benefits.
- 611 D. Contractor shall maintain a network of appropriate providers supported by written  
612 agreements. The beneficiary may choose amongst the available providers within  
613 the plan's network.
- 614 E. Contractor shall maintain a network of appropriate providers sufficient to provide  
615 adequate access to all services covered under the contract.

- 616 F. Contractor must work towards being certified by the National Committee for  
617 Quality Assurance (NCQA).  
618 G. Contractor must ensure all beneficiary protections required in federal and State  
619 statutes and regulations for Medicare and Medicaid beneficiaries.  
620 H. Contractor shall safeguard the privacy of enrollee health records and provide  
621 enrollees access to the records upon request.  
622 I. Customer service representatives (CSRs) must be available for a minimum of  
623 forty hours per week during standard business hours. CSRs must be sensitive to  
624 the language and culture of the participant, and they must be able to answer  
625 enrollee questions and respond to complaints and concerns appropriately.  
626 I. In establishing and maintaining its network of providers, Contractor must  
627 consider the following:  
628 1. The anticipated Medicaid enrollment;  
629 2. The expected utilization of services, taking into consideration the  
630 characteristics and health care needs of specific Medicaid populations  
631 represented among Contractor's enrollees;  
632 3. The numbers and types (in terms of training, experience, and  
633 specialization) of providers required to furnish the contracted Medicaid  
634 services;  
635 4. The numbers of network providers who are not accepting new Medicaid  
636 patients; and  
637 5. The geographic location of providers and Medicaid enrollees, considering  
638 distance, travel time, the means of transportation ordinarily used by  
639 Medicaid enrollees, and whether the location provides physical access for  
640 Medicaid enrollees with disabilities.

641  
642  
643 Contractor agrees to facilitate reasonable access to medical care for enrollees. The following  
644 time frames should be adhered to, to provide reasonable access to care:  
645

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	
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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 beneficiary grievance and appeal process is included in Attachment 11.

- 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 the next is scheduled for May 10<sup>th</sup>, 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 will be held on April 17th to discuss the proposal. A survey and a feedback form are also available on the website.

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

703

### 704 ***E. Financing and Payment***

705

706 i. Payment reforms and financial alignment model.

707

708 The capitation financing model will be used in this initiative. Participating plans will receive a  
709 per member per month payment (PMPM) for each enrollee in exchange for delivering the  
710 integrated set of Medicare and Medicaid benefits. The exact amount of that payment will be  
711 based on an actuarial analysis of historical costs and anticipated savings resulting from the  
712 integration of services and improved care management. The contracting health plans will  
713 assume full risk for all required services for enrollees. Payments will be adjusted based on  
714 health plan performance with respect to pre-determined quality measures. Any savings from the  
715 program will be shared by Medicare and Medicaid in proportion to contributions made by the  
716 two programs. It is important and helpful from the State's perspective that any savings will be  
717 shared in this initiative, because most savings in integrated Medicare-Medicaid health plans are  
718 expected to be seen from reduced primary and acute costs, which are covered primarily by  
719 Medicare.<sup>5</sup>

720

721 ii. Payments to providers.

722

723 Critical steps in the rate development process include the following:

724

- 725 • The State provides summaries of monthly eligibility and claim experience for each  
726 MMCP enrollee on a PMPM basis to facilitate the analysis for the actuarial rate  
727 certification. The summary will be based on the claims detail for the 36-month period of  
728 7/1/2008 – 6/30/2011. The detailed claims data will be summarized by service category  
729 and membership months for each of the counties and populations of dual and non-dual  
730 beneficiaries. The data is then mapped into rate categories.
- 731 • Base experience will include all services to be covered by the health plan.

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<sup>5</sup> "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](http://www.chcs.org/usr_doc/Payment_and_Reimbursement_FINAL.pdf).

- 732       • The cost projections include adjustments for trend, health care management, selection  
733       and health plan administrative costs.

734  
735 The Medicaid capitation payment does not include physician incentive payments. The  
736 Contractor must comply with all requirements and limitations set forth in 42 CFR § 422.208 and  
737 42 CFR § 422.210. The Contractor must submit a report to the Department quarterly which  
738 summarizes all incentive payments made. The report shall include what the incentive payment  
739 was for and the amount of the incentive payment. The Contractor shall provide to enrollees,  
740 upon request, physician incentive payment program information.

741  
742 ***F. Expected Outcomes***

- 743  
744       i. Ability of the State to monitor, collect and track data on key metrics related to quality and  
745       cost outcomes

746  
747 The State will require the health plans to monitor, collect, and track data on key cost and quality  
748 metrics, including beneficiary experience, access to and quality of all services, utilization, etc.  
749 The State will conduct surveys and pull claims data to determine financial trends. Specific  
750 potential metrics include provider/beneficiary ratios, decreases in hospitalizations, wait times for  
751 appointments, percent of individuals receiving yearly visits to their primary care physicians,  
752 percent of individuals receiving preventive care, etc. A detailed set of metrics will be developed  
753 and included in the three-way contracts. The State has a Medicaid Management Information  
754 System (MMIS) to access Medicaid claims data. A joint selection process will be used with  
755 CMS to determine which quality measures will be considered for purposes of payments to health  
756 plans.

- 757  
758       ii. Potential improvement targets for quality measures

- 759  
760       • The size of the network of appropriate providers  
761       • The numbers of network providers who are accepting new Medicaid patients  
762       • The number of beneficiaries  
763       • The provider/beneficiary ratio  
764       • Number of hospitalizations  
765       • Wait times for appointments  
766       • Number of skilled nursing facility admissions

767  
768 The State will work with stakeholders to develop specific numerical targets and measures to  
769 ensure that appropriate standards are in place to ensure a high quality of care.

- 770  
771       iii. Expected impact on Medicare and Medicaid costs.

772 Although the exact savings are uncertain, the potential is significant. According to the an August  
773 2011 study from Special Needs Consulting Services (SNCS), Idaho can expect to save  
774 \$8,426,110 for each 1% in savings on the current money paid for dual eligible individuals'

775 services through the fee-for-service system.<sup>6</sup> Further, the SCNS study references a 2008 Lewin  
776 Group report which indicates that an optimal coordinated care program could save an average of  
777 3.7% on dual eligibles' costs over a ten-year timeframe.<sup>7</sup> The same report estimated Year 1  
778 savings to be 2.7%. Idaho Medicaid and CMS will collaborate on developing more precise  
779 estimates of individual and combined expenditures and savings for Medicaid and Medicare in the  
780 three years of the demonstration.

781  
782 ***G. Infrastructure and Implementation***  
783

- 784 i. Description of State infrastructure/capacity to implement and oversee the demonstration.  
785

786 Idaho is prepared to devote the necessary staff to ensure the initiative is successful. The  
787 following is a list of staff members who will be involved in the project:  
788

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 Specialists:	Tom Shanahan
	Shannon Winget
	Shelby Spangler

789  
790 Idaho currently has significant ability to access Medicare cost reports through a Certified Public  
791 Accounting (CPA) firm, Meyers and Stauffer. Access varies depending on the type of provider,  
792 as described below:  
793

794 **Hospitals**

795 One of Meyers and Stauffer's contractors receives ECR/MCR cost reports that are housed on  
796 their server. The State does not have direct access to the contractor's server so data must be  
797 requested separately. The cost reports aren't requested by the contractor until after the Medicare  
798 audit is complete so the data they currently have is 2-3 years old. However, the contractor is

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<sup>6</sup> Special Needs Consulting Services. "Achieving Optimal Care Coordination for Medicaid/Medicare Dual Eligibles." (August 2011).

<sup>7</sup> The Lewin Group. "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities" (November 2008).

799 working on a method to download HCRIS electronic data from the CMS website to have access  
800 to more current cost reporting data.

801

### 802 **Nursing Facilities**

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

806

### 807 **Home Health Agencies (HHAs)**

808 Meyers and Stauffer only receives paper cost reports and has no access to electronic data.

809

### 810 **FQHCs**

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

813 Idaho Medicaid will provide CMS with any needed data upon request, including but not limited  
814 to expenditure and encounter data. Idaho Medicaid also intends to use the process CMS has  
815 made available in order to access timely Medicare Parts A and B claims data and D event data,  
816 and Medicare Parts A, B, C, and D eligibility and enrollment data.<sup>8</sup>

817 ii. Implementation strategy / anticipated timeline

818

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

821

### 822 **H. Feasibility and Sustainability**

823

824 i. Potential barriers/challenges.

825

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

833

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

838

839 ii. Remaining statutory and/or regulatory changes needed.

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<sup>8</sup> “Medicare Data for Dual Eligibles for States.” Centers for Medicare and Medicaid Services.  
[https://www.cms.gov/medicare-medicare-coordination/06\\_MedicareDataforStates.asp](https://www.cms.gov/medicare-medicare-coordination/06_MedicareDataforStates.asp)

840  
841 Significant regulatory and statutory changes are needed in order to implement this initiative. For  
842 instance, IDAPA §16.03.17, the section containing the current MMCP §1937 benefits plan, will  
843 need to be replaced by 2014. Minor revisions will also be needed to IDAPA §16.03.09 and  
844 IDAPA §16.03.10. Further, a statutory revision is needed in Idaho Code §56-254, also due to  
845 the MMCP §1937 benefits plan being replaced.

846  
847 iii. New State funding commitments or contracting processes needed.

848  
849 A funding commitment will be needed to implement required systems changes. Contracts will  
850 need to be agreed to by the health plans, CMS, and Idaho Medicaid before implementing  
851 enrollment into the coordinated health plans in 2014. The procurement process will need to be  
852 followed.

853  
854 iv. Scalability and replicability in other settings/States.

855  
856 The managed care model should be replicable in other States and settings. In fact, managed care  
857 programs have already been successful in a number of settings and States. As of 2009, CMS  
858 statistics show that more than 70% of Medicaid enrollees were members of managed care plans.<sup>9</sup>  
859 Idaho is a large State that is sparsely populated. If the model proves successful here, it should  
860 also prove successful if replicated in states with more managed care organizations and providers  
861 already in place. This model should help other large, rural states address the challenges created  
862 by such conditions. If managed care is successful with the dual eligible population in Idaho, the  
863 State will consider bringing additional populations within the State into managed care systems.

864  
865 v. Letters of support

866  
867 Please refer to attachments at end of document for letters of support and as well as text from  
868 relevant portion of Idaho House Bill 260.

869  
870

### 871 ***I. Additional Documentation***

872  
873 Additional documentation will be made available as various steps in the process are completed.  
874 Some of the additional documentation which will be completed includes:

- 875
- 876 1) State Plan Amendment to §3.1-C of the Medicaid State plan
  - 877 2) Statutory revision to Idaho Code §56-254
  - 878 3) Regulatory revision to replace IDAPA §16.03.17
  - 879 4) 1915(b) waiver application
  - 880 5) Amendments to Idaho's 1915(c) waivers (Aged and Disabled waiver, and
  - 881 Developmentally Disabled waiver)
- 882

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<sup>9</sup> "Medicaid Managed Care Enrollment as of July 1, 2010." Centers for Medicare and Medicaid Services.  
<http://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2010July1.pdf>.

883 **J. Interaction with Other HHS/CMS Initiatives**

884  
885 Idaho intends to use the demonstration for dual eligibles as an additional way of identifying  
886 individuals who would be appropriate for the Idaho Home Choice - Money Follows the Person  
887 program, which allows individuals to move from institutional settings into the community.  
888 Within one year from the time of an individual’s enrollment, the health plan will evaluate that  
889 person’s suitability for the program, based on the following requirements:

- 890
- 891 a. A participant must have been in a Nursing Facility, Intermediate Care Facility for  
892 People with Intellectual Disabilities (ICF/ID), or an Institution for Mental Disease  
893 (IMD) for a minimum of 90 days (excluding any Medicare Part A days);
  - 894 b. A participant must wish to move out of the institution and into a community  
895 setting; and
  - 896 c. A participant must be Medicaid-eligible at the time of discharge and a resident of  
897 Idaho (these requirements should always be met if an individual participates in the  
898 coordinated plan for dual eligibles).
- 899

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

903  
904 This demonstration also fits well with CMS’ *Partnership for Patients* project, which seeks to  
905 reduce all hospital readmissions by 20% between 2010 and 2013. A reduction in hospital  
906 readmissions of dual eligibles is one of the goals of this project, and health plans will track data  
907 on this quality measure. Many hospital readmissions are caused by inadequate transitions from  
908 one care setting to another. The dual eligibles’ primary care teams will take an active role in  
909 planning a thoughtful, effective transition, and this will help to minimize the risk of a  
910 readmission.

911  
912 For similar reasons, CMS’ *Reducing Avoidable Hospitalizations Among Nursing Home*  
913 *Residents* initiative also fits well with this demonstration. CMS research has indicated that 45%  
914 of hospital admissions for those receiving Medicaid nursing facility services are preventable.<sup>10</sup>  
915 Principles being implemented in this proposal, such as care coordination, transition planning,  
916 preventive care and evidence-based practices are principles that should help to reduce avoidable  
917 hospitalizations in the nursing home setting.

918  
919 Last, this initiative should help to further the goals of the *Million Hearts* initiative. While the  
920 care integration effort is not directly connected to *Million Hearts*, better care coordination and a  
921 greater emphasis on prevention should help reduce heart attacks and strokes. This may occur as  
922 a result of aspirin therapy, lifestyle changes, or in some cases through medications for blood  
923 pressure or cholesterol. From a broader perspective, better monitoring of a wide variety of risk  
924 factors for many health problems should be in place with the participation of the managed care

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<sup>10</sup> “Reducing Avoidable Hospitalizations Among Nursing Home Residents.” Centers for Medicare and Medicaid Services. [https://www.cms.gov/medicare-medicaid-coordination/09\\_ReducingAvoidableHospitalizationsAmongNursingFacilityResidents.asp](https://www.cms.gov/medicare-medicaid-coordination/09_ReducingAvoidableHospitalizationsAmongNursingFacilityResidents.asp)

925 health plans in 2014. This should help to achieve the ultimate goal of this project: better health  
926 for Idaho's citizens who are enrolled in Medicare and Medicaid.  
927  
928

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929 **K. Workplan/Timeline**

930

<b>Planned Completion Date/Status</b>	<b>Key Activities/Milestones</b>	<b>Responsible Party/Parties</b>	<b>Status</b>
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
October 1, 2011	Submit letter of intent to CMS by October 1 <sup>st</sup> , 2011; submitted on September 25 <sup>th</sup> , 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

February 15, 2012	Insert fiscal projections after actuarial report completed.	State	In process
March 2, 2012	Meeting with health plans.	Health Plans / State	Complete
April 2, 2012	Submission of draft to project team.	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	Scheduled
May 10, 2012	Meeting with health plans.	Health Plans/State	Incomplete
Late May 2012	Incorporate feedback into proposal, and obtain sponsor final approval.	State	Incomplete
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
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	Health Plans	Incomplete

	ensure user access to the CMS HPMS for purposes of submission of formulary and plan benefit package information.		
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	<ul style="list-style-type: none"> <li>• Readiness review for participating plans</li> <li>• Contract negotiations with participating plans</li> </ul>	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	<ul style="list-style-type: none"> <li>• State Plan Amendment work initiated (if needed)</li> <li>• Solicit input from tribes via tribal notice</li> </ul>	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	<ul style="list-style-type: none"> <li>• Legal notice of SPA</li> <li>• Submit SPA to CMS</li> </ul>	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	<ul style="list-style-type: none"> <li>• System requirements and cost estimates</li> <li>• Secure funding via administration</li> </ul>	State	Incomplete
October 2013 to December 2013	<ul style="list-style-type: none"> <li>• System changes made</li> <li>• Implementation readiness review</li> </ul>	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	<ul style="list-style-type: none"> <li>• Enrollment effective date</li> <li>• Implementation work begins</li> <li>• Beneficiary notification of enrollment processes</li> <li>• New rules in Idaho Administrative Procedure Act (IDAPA) implemented</li> </ul>	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.		

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939

**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

- 940 6) Letter of Support – PacificSource Health Plans, Dave Self
- 941 7) Letter of Support – UnitedHealthcare, Catherine Anderson
- 942 8) Letter of Support – Idaho Governor’s Office
- 943 9) Text of relevant portion of Idaho House Bill 260
- 944 10) Tribal Notice Letter
- 945 11) Attachment 11 - Enrollee Grievance and Appeal Process for Integrated Services

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947 **Dual Eligibles Financing Model Discussion**948 **September 26, 2011**949 **2:00 p.m. – 4:00 p.m.**

950 3232 Elder Street, Boise, ID 83705 208.334.5747

951 Conference Room D-West

952 **Attendees:**

953 DHW: Richard Armstrong, Leslie Clement Medicaid: Paul Leary, Natalie Peterson, Lisa

954 Hettinger, Sheila Pugatch, Michele Turbert, Cynthia York, Robert Kellerman

955 Health Plans: Mark Bryan, Matthew Moore, Jeanne Phillips, Dave Self, Rhonda Busek,

956 Catherine Anderson, Jenny Eidenbrook, Jack Myers, Jerry Dworak, Ricki Watts. Invited, not in

957 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

958 **To Be Discussion:**

959

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

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

966

967 What are the barriers to enrollment?

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

973

974 What are the strengths of the current MMCP?

- 975 • Individualized coordination of care
- 976 • Care manager assigned to participants
  - 977 ○ Frequent ER visits
  - 978 ○ Medication management
  - 979 ○ Medical home – incentivize prevention

980

981 What are the opportunities for improvement for the current MMCP?

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

986

987 What are your thoughts about the fully integrated model?

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

993

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

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

997

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

- 1000 • Identify needs and use funds to make good decisions for population
- 1001 • Flexibility to use funds
  - 1002 ○ This is a key element to capture what the flexible funding is supposed to achieve

- 1003       • Aligning services sooner
- 1004       • Consider HCBS light to provide services to those not yet institutional level but close
- 1005
- 1006   What are your thoughts to ensure access to the full continuum of services, including community-
- 1007   based care options?
- 1008       • Think about how to incent providers to participate
- 1009       • Phase in provider network
- 1010           ○ All in for existing network provides stability
- 1011
- 1012   What are your thoughts about whether certain subpopulations should be excluded?
- 1013       • Different payments for different populations to recognize different services needed
- 1014       • Idaho may want to consider a Cost + financing model
- 1015       • May want to consider a phase in approach for certain populations
- 1016
- 1017   What is your readiness to handle the delivery of the full scope of benefits?
- 1018       • Blue Cross recently completed a readiness assessment and has the core elements in place
- 1019       • United is currently operating in 20 + States
- 1020       • Need to take into consideration contract development timeframes
- 1021           ○ This is a very fast time line – would take considerable effort to implement by end
- 1022           of 2012
- 1023       • Hiring care management clinical staff would take approximately 4-8 months

1024 **Attachment 2 – Managed Care Redesign Long Term Care For Dual Eligible Beneficiaries**  
 1025 **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.**

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

1026  
 1027 **Question 1. The majority of dual eligibles is older than 65 years of age, but also includes**  
 1028 **individuals who are younger than 65 years of age and disabled. Should the managed care**  
 1029 **contracts include all duals or would you recommend a phased-in approach for certain**  
 1030 **subgroups of duals?**

1031  
 1032 Remember that more dual eligible nursing home residents are younger these days, under 65, and  
 1033 there needs to be an improved option for them.

1034

1035 Agrees, both suggested carving out older individuals from this plan. Younger people are an ideal  
1036 population for managed care, due to having fewer chronic conditions and greater potential for  
1037 improvement and savings.

1038  
1039 Start with those participants with chronic care needs. Look at managed care from a utilization  
1040 standpoint, and not age. Ensure that you review utilization sub-groups; utilization distinctions  
1041 are more important than age distinctions.

1042  
1043 Agrees, don't use age use needs

1044  
1045 Why have any exclusions? If it is a desirable option, leave it open for all right away.

1046  
1047 **Question 2: What performance requirements should Idaho Medicaid require of the**  
1048 **managed care contracts to ensure that dual eligibles receive the best quality of care?**

1049  
1050 Everything in her slides should be required. It should not be based just on cost savings, but  
1051 rather on ease of access and quality of life.

1052  
1053 A holistic model should be used. It needs to be consumer-directed. Have providers, MCO's, and  
1054 individuals at the table together so that the MCO's will be more accountable and responsive.

1055  
1056 Prompt payment to providers is important

1057  
1058 Strong State oversight is critical; be sure that Medicaid partners with the MCO to create  
1059 benchmarks they are expected to attain. Ensure that those benchmarks include both provider and  
1060 consumer satisfaction, and require timely access and payments. Meaningful benchmarks are  
1061 critical; assuring access to services must be a benchmark as well as good pay for providers.

1062  
1063 The consumer/care coordinator relationship needs to be measured; it must be strong for this to  
1064 work.

1065  
1066 **Question 3: The managed care contractors are responsible for establishing provider**  
1067 **contracts across the range of medical, behavioral health and LTC benefits. Other than**  
1068 **requirements that ensure access to services, what other standards should be used by the**  
1069 **managed care contractors to establish provider contracts?**

1070  
1071 We need legislation that says long standing (10Yrs.), established providers can not be excluded.  
1072 Specialists are often out of network and that is a problem; they sometimes do not participate in  
1073 managed care.

1074  
1075 One managed care plan is a nightmare; rates are too low, and we can't get a contract with them.  
1076 We have to jump through hoops through reimbursement. We need to let all providers participate  
1077 in the network.

1078  
1079 Lewin Group has some good research that says MCOs fail if they drive utilization to too few  
1080 providers. Do not allow managed care add more bureaucracy. More rules would be a barrier to

1081 access since we already have many rules with Medicaid and Medicare. Managed care fails if it's  
1082 just based on price.

1083  
1084 MCO should establish baseline standards for providers to ensure access to services. There needs  
1085 to be real clarity to consumers about options, benefits, etc.

1086  
1087 Reward good providers and don't reward bad providers. Quality standards need to line up with  
1088 what will be paid for. All must agree on what good quality is. Quality should be defined  
1089 without making it unnecessarily complicated.

1090  
1091 **Question 4: Should Idaho require the managed care contractors to include primary care**  
1092 **medical homes for people with chronic conditions?**

1093  
1094 Yes. The Healthy Connections concept, which already includes medical homes, is good.

1095  
1096 Idaho has a shortage of primary care physicians. It would be good to implement them, but it  
1097 would be challenging due to the shortage of primary care physicians.

1098  
1099 Medical home model is a good one but it is complicated to achieve in rural areas.

1100  
1101 **Question 5: What managed care contract requirements should be established to prevent**  
1102 **and reduce inpatient hospitalization and nursing home admissions?**

1103  
1104 A RALF or facility may take a participant who has more intensive needs than they're capable of  
1105 dealing with, and then 9-1-1 becomes the facility's nurse if no other resources are available.

1106  
1107 Home care does not work for everyone; there is no guarantee of services in home care. MCO  
1108 need to help move folks from higher cost settings to lower cost care settings where appropriate.  
1109 It is a myth that people can be guaranteed the services that they're supposed to get in the in home  
1110 care setting.

1111 Contract needs to spell out the services and should exclude the "middle man." Remove the  
1112 regulations "Handcuffs." Adopt uniform standards or supplement State standards. Choose the  
1113 appropriate setting, even if it's outside the box.

1114  
1115 Medicare and Medicaid need to be coordinated. Savings should not go to MCO, but \$ should be  
1116 used to improve care. Some States actually expand services under managed care. Numbers with  
1117 NF Level of Care have been seen to decrease with managed care.

1118  
1119 Coordinate plan with Medicaid and Medicare; coordination is key. Eliminate cost-shifting.

1120  
1121 **Question 6: How should advanced illness care planning and palliative care services be**  
1122 **made available early in the onset of a life-limiting condition to assist the patient to make**  
1123 **informed decisions in keeping with their personal values and avoiding expensive services**  
1124 **that increase risk of harm and do not lengthen life or improve quality of life?**

1125  
1126 Huntingtons patients...it is important to catch conditions early enough to help people.

1127  
1128 Everyone should have a right to live with dignity but provisions for services that do not help  
1129 should not be paid for. It's not always the best thing to do everything possible in all situations.  
1130 However, rights issues come into play. Managed care must meet humanity. The dual eligible  
1131 population is likely to increase significantly by 2014.

1132  
1133 Create incentives for people to have a "Living Will."  
1134

1135 **Question 7: How should patient choice be protected while offering the safest, most effective**  
1136 **level of care and services in a streamlined, seamless manner during transitions between**  
1137 **care settings, e.g. when discharged from the hospital?**  
1138

1139 Person-centered discharge planning is critical and it takes skill and training. Look at all options  
1140 at discharge to deflect re-admittance; consider goals, needs, dreams, and facts. Use available  
1141 supports/services to come up with the best plan; consider prevention.  
1142

1143 MCO needs to be the one stop shop for learning about all options, not just select options.  
1144 Options are often not available in rural areas. He likes the Oregon model, but does not like the  
1145 Texas model. Meaningful interaction with the case manager is key. Managed care will force  
1146 decisions upon consumers that they don't like, and so the quality of case management to work  
1147 through that is imperative.  
1148

1149 Not all providers like the Oregon model. You need to assure true consumer choice; not just  
1150 MCO only selected options/providers. Don't want the consumer getting a MCO's "preferred  
1151 provider list."  
1152

1153 You want government oversight to prevent provider favoritism by MCOs.  
1154

1155 **Question 8: What managed care contract requirements should be established for working**  
1156 **with certified family home providers?**  
1157

1158 Need safeguards protecting people from limited choices since they are living in someone else's  
1159 house. CFH's need to be part of the puzzle; there are more than 2,000 in Idaho.  
1160

1161 Find a balance between personal and State responsibility. Gov. Otter talks about caring for your  
1162 family.  
1163

1164 Most people in nursing homes do not have home supports, CFH's should not be for profit.  
1165 There's a place for it, but he struggles with the idea of the family being paid.  
1166

1167 **Question 9: What are the opportunities to reduce duplication and conflicting requirements**  
1168 **between Medicare and Medicaid?**  
1169

1170 There should be a laundry list of options; look at streamlining and offer lots of options.  
1171 Medicare will pay for brain surgery but not a bath aid.  
1172

1173 MCO should use technology to track and coordinate care, avoid duplication, and catch  
1174 medication errors.

1175  
1176 Rules should not define what medical equipment is available to patients. Patient should decide  
1177 what fits best.

1178  
1179 **Question 11: How should the Money Follows the Person demonstration project work with**  
1180 **the managed care contractors to support the HCBS infrastructure and systems for the**  
1181 **duals?**

1182  
1183 MFP excludes certain care settings, so it's already flawed since it determines what the settings  
1184 can be. Don't exclude certain care settings.

1185  
1186 MFP designed by CMS rules, not the States. It was designed to help people out of institutions.  
1187 Sometimes there aren't enough community options, and that limits people's choices.

1188  
1189 MFP and MCO dovetail well together.

1190  
1191 Agrees. Helps provide good support services for people, and helps people to be connected with  
1192 family in community.

1193  
1194 **Question 13: What managed care contract requirements should be established to support**  
1195 **dual eligibles that choose to work?**

1196  
1197 We are not all sick; we are people with unique needs. Had 4 insurance plans at one time. Don't  
1198 put us in a category. She wanted to know how long she'd be in the hospital when she had to go.  
1199 You need to have good coordination with all providers whose services are being accessed.

1200  
1201 **Question 14: How should Idaho Medicaid receive ongoing input from duals, providers, and**  
1202 **other stakeholders?**

1203  
1204 Ongoing work group with a variety of people involved to work with Leslie over time is key.  
1205 Provider and public feedback is important. Legislation needs to be crafted together, or there will  
1206 be a fight. These discussions need to continue. A 2012 implementation is too quick. It should  
1207 slow down. We need to learn the lessons from last year's education reform because they went  
1208 too fast without including important groups in the process. The public needs to be informed as  
1209 this goes along.

1210  
1211 The Community Care Council is a good forum to report to the legislature about this effort and  
1212 how it is going. Give a report with a grade for each benchmark.

1213  
1214 There needs to be an oversight committee with a real voice, not just a token to hear what the  
1215 Department has already decided. We need active participation from the committee.

1216  
1217 There should be more publicity so that the public can be involved in the process.

1218

- 1219 Use SILS and AAA to continue the public forums across the State. If we're not involved in this,  
1220 we'll fight it to the bone.  
1221  
1222 Posting of questions and responses to website is good.

DRAFT

## Attachment 3 – Letter of Support – Blue Cross of Idaho, Jack Myers



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NOV 15 2011

DEPARTMENT OF HEALTH AND WELFARE  
OFFICE OF THE DIRECTOR

November 9, 2011

Leslie Clement, Deputy Director  
Idaho Department of Health and Welfare  
450 West State St.  
Boise, ID 83720

Dear Ms. Clement:

Blue Cross of Idaho strongly supports the State of Idaho's initiative to collaborate with the Centers for Medicare and Medicaid Services (CMS) on coordinating care for the Dual Eligible population through a managed care program. We at Blue Cross of Idaho have developed a strong Medical Management program that has been effective in reducing cost, while improving quality for both our commercial and Medicare Advantage populations. In fact, NCQA gave us a score of 100% for our model of care submission, which describes our processes for effective management of care and transition of care across multiple settings. Effective care coordination programs such as these, applied to the Dual Eligible population, will likewise improve Medicaid cost effectiveness and quality.

The same model of care is used to manage our current population of 650 Idaho Dual Eligible members. Under your proposed collaborative coordinated care program, many more Dual Eligibles will experience improved quality of care.

We have appreciated the opportunity to be involved in the process from early on, including the meeting on September 26, 2011. We look forward to contributing to a timely and successful implementation. You have our commitment to continue to collaborate with Medicaid to ensure high-quality, well-coordinated care for individuals with dual eligibility.

Sincerely,

Jack Myers  
Executive Vice President and CFO

JM/sh

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**Attachment 4 – Letter of Support – Windsor/Sterling Health Plans, Matthew Moore**



**WINDSOR**

11/11/11

Leslie Clement, Deputy Director  
Idaho Department of Health and Welfare  
450 West State St.  
Boise, ID 83720

Dear Ms. Clement:

We are very pleased to offer this letter in support of Idaho's initiative to collaborate with the Centers for Medicare and Medicaid Services (CMS) on coordinating care for the dual eligible population through a managed care program. The population eligible for both Medicaid and Medicare has extensive health care needs, and all too often receives poorly coordinated care. We are enthusiastic about the effort to provide fully integrated, seamless care for these individuals. This much-needed program presents a valuable opportunity to improve both the quality and cost-effectiveness of care for people with dual eligibility.

We are committed to being involved in this effort in a meaningful way. We have appreciated the opportunity to be involved in the process from early on, including the meeting on September 26, 2011. We look forward to contributing to a timely and successful implementation. We are excited to continue to collaborate with Medicaid to ensure high-quality, well-coordinated care for individuals with dual eligibility.

Sincerely,



Matthew Moore

Regional President  
Windsor/Sterling Health Plans

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## Attachment 5 – Letter of Support – Idaho Commission on Aging, Sam Haws



### IDAHO COMMISSION ON AGING

• 341 W. Washington, 3<sup>rd</sup> Floor Boise, Idaho 83702 • P.O. Box 83720 Boise, Idaho 83720-0007  
• Telephone: 208-334-3833 • Facsimile: 208-334-3033 • Web site: [www.idahoaging.com](http://www.idahoaging.com)

C.L. "Butch" Otter, Governor  
Sam Haws, Administrator

Date: 11/21/2011

Leslie Clement, Deputy Director  
Idaho Department of Health and Welfare  
450 West State St.  
Boise, ID 83720

Dear Ms. Clement:

Thank you for giving Idaho Commission on Aging the opportunity to participate in the October 27<sup>th</sup> Idaho stakeholder public forum to seek input on the redesign of the managed care program to better coordinate care for dual eligible individuals. It is our belief that gathering stakeholder perspectives concerning how to more effectively integrate the Medicare and Medicaid programs will lead to the ultimate goal of improving both the quality and cost-effectiveness of care for people with dual eligibility.

The population eligible for both Medicaid and Medicare has extensive health care needs, and improvements are needed to provide fully integrated, seamless care for this group. We are committed to being involved in this effort in a meaningful way and are excited to collaborate with Medicaid to ensure high-quality, well-coordinated care for individuals with dual eligibility.

Our organization supports Idaho's initiative to collaborate with the Centers for Medicare and Medicaid Services (CMS) to coordinate care for the dual eligible population in a manner that involves meaningful stakeholder involvement.

Thank you again for the opportunity to participate.

Sincerely,

  
Sam Haws,  
ICOA Administrator

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**Attachment 6 – Letter of Support – PacificSource Health Plans, Dave Self**



November 17, 2011

**RECEIVED**  
**NOV 21 2011**  
DEPARTMENT OF HEALTH AND WELFARE  
OFFICE OF THE DIRECTOR

Leslie Clement, Deputy Director  
Idaho Department of Health and Welfare  
450 West State St.  
Boise, ID 83720

Dear Ms. Clement:

We are very pleased to offer this letter in support of Idaho's initiative to collaborate with the Centers for Medicare and Medicaid Services (CMS) on coordinating care for the dual eligible population through a managed care program. The population eligible for both Medicaid and Medicare has extensive health care needs, and all too often receives poorly coordinated care. We are enthusiastic about the effort to provide fully integrated, seamless care for these individuals. This much-needed program presents a valuable opportunity to improve both the quality and cost-effectiveness of care for people with dual eligibility.

We are committed to being involved in this effort in a meaningful way. We have appreciated the opportunity to be involved in the process from early on, including the meeting on September 26, 2011. We look forward to contributing to a timely and successful implementation. We are excited to continue to collaborate with Medicaid to ensure high-quality, well-coordinated care for individuals with dual eligibility.

Best Regards,

A handwritten signature in black ink, appearing to read "Dave Self".

Dave Self  
Senior Vice President &  
Idaho Regional Director

Bend Eugene Medford Portland Boise Coeur d'Alene Idaho Falls  
PacificSource.com

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**Attachment 7 – Letter of Support – UnitedHealthcare, Catherine Anderson**



Catherine K. Anderson, MPA  
National Vice President  
Complex Care Products  
UnitedHealthcare Community & State  
37 West 2000 South  
Driggs, ID 83422

Leslie Clement, Deputy Director  
Idaho Department of Health and Welfare  
450 West State Street  
Boise, ID 83720

Dear Ms. Clement:

We are pleased to support the State of Idaho's goals of improving the quality of care provided to individuals who are eligible for Medicare and Medicaid. Idaho has demonstrated its interest in developing innovative models for Medicare-Medicaid Enrollees through the early adoption of Deficit Reduction Act (DRA) Benchmark authority and the creation of the Medicare/Medicaid Coordinated Program (MMCP). This program maximized the authority available to the State at the time and created a model to improve coordination for Medicare and Medicaid benefits for individuals who chose to participate.

United was supportive of Idaho's commitment to improve coordination for people participating in MMCP and worked in cooperation with the State from the program inception through the end of this calendar year. We continue to be interested in working closely with you to improve care to Medicare-Medicaid Enrollees and are pleased to support your efforts to implement an integrated approach based upon the financial models proposed by CMS.

We offer our national experience in shaping an effective, integrated program for Idaho's Medicare-Medicaid Enrollees. We were pleased to participate in the meeting with other interested health plans on September 26, 2011 and are committed to participation in additional health plan meetings, stakeholder and advocacy outreach, and interactions with the Medicare-Medicaid Coordination Office as necessary.

If I can be of assistance, please feel free to contact me. Thank you for your commitment to engage UnitedHealthcare and other health plans in a meaningful dialogue. We look forward to the ability to shape a program that improves quality and reduces the costs associated with these complex individuals.

Sincerely,

A handwritten signature in blue ink that reads 'Catherine K. Anderson'.

Catherine K. Anderson, MPA  
National Vice President, Complex Care Products  
UnitedHealthcare Community & State

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Attachment 8 – Letter of Support – Idaho Governor’s Office



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C.L. “BUTCH” OTTER GOVERNOR

December 6, 2011

1247 Leslie Clement, Deputy Director  
1248 Idaho Department of Health and Welfare  
1249 450 W. State St.  
1250 Boise, ID 83720

1251  
1252 Dear Deputy Director Clement,

1253  
1254 I support Idaho Medicaid’s initiative to collaborate with the Centers for Medicare and Medicaid Services  
1255 (CMS) in coordinating care for the dual eligible population through a managed care program. The  
1256 population eligible for both Medicaid and Medicare has extensive health care needs, and while they  
1257 comprise just 15 percent of Medicaid enrollees, they account for 39 percent of all Medicaid spending.  
1258 This program presents a valuable opportunity to address important issues for this population.

1259  
1260 I understand that the key features of the program would include:

- 1261
- 1262 • Three party-contracts between Idaho Medicaid, the Centers for Medicare and Medicaid Services,
- 1263 and the insurers
- 1264 • Capitation payments to the insurer
- 1265 • Coordination of care by the insurer, including coverage of all Medicaid and Medicare-covered
- 1266 benefits
- 1267 • The integration of benefits by the insurer so that the beneficiary has a seamless, well-coordinated
- 1268 experience.
- 1269

1270 This initiative is consistent with the direction in which Idaho is moving in health care. House Bill 260  
1271 directed Medicaid to develop managed care programs that result in an accountable care system with  
1272 improved health outcomes, and this initiative, when completed, will certainly fulfill that requirement.

1273  
1274 Thank you for your continued hard work to provide Idaho’s dually eligible citizens with high-quality,  
1275 well-coordinated health care services.

1276  
1277

As Always – Idaho, “Esto Perpetua”

C.L. “Butch” Otter  
Governor of Idaho

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1286 **Attachment 9 – Idaho House Bill 260**  
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1288 According to Idaho’s HB 260, 56-263:  
1289

1290 **MEDICAID MANAGED CARE PLAN.**  
1291

1292 (1) The department shall present  
1293 to the legislature on the first day of the second session of the sixty-first  
1294 Idaho legislature a plan for Medicaid managed care with focus on high-cost  
1295 populations including, but not limited to:  
1296

- 1297 (a) Dual eligibles; and
- 1298 (b) High-risk pregnancies.
- 1299

1300 (2) The Medicaid managed care plan shall include, but not be limited to,  
1301 the following elements:  
1302

- 1303 (a) Improved coordination of care through primary care medical homes.
- 1304 (b) Approaches that improve coordination and provide case management  
1305 for high-risk, high-cost disabled adults and children that reduce costs  
1306 and improve health outcomes, including mandatory enrollment in special  
1307 needs plans, and that consider other managed care approaches.
- 1308 (c) Managed care contracts to pay for behavioral health benefits as  
1309 described in executive order number 2011-01 and in any implementing  
1310 legislation. At a minimum, the system should include independent, standardized,  
1311 Statewide assessment and evidence-based benefits provided by businesses  
1312 that meet national accreditation standards.
- 1313 (d) The elimination of duplicative practices that result in unnecessary utilization  
1314 and costs.
- 1315 (e) Contracts based on gain sharing, risk-sharing or a capitated basis.
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**Attachment 10 – Tribal Notice Letter**



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

1334

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

1335 April 3, 2012

1336

1337 *Dear Tribal Representative:*

1338

1339 The purpose of this letter is to let you know that Idaho Medicaid intends to submit a proposal to  
1340 the Centers for Medicare and Medicaid Services (CMS) in order to participate in the  
1341 Demonstration to Integrate Care for Dual Eligible Individuals, starting on January 1, 2014. We  
1342 intend to submit the proposal to CMS no later than May 31, 2012. In this program, full dual  
1343 eligible individuals (people who have Medicare and full Medicaid benefits) will be enrolled into  
1344 a managed care health plan which will cover and coordinate their Medicare and Medicaid  
1345 benefits, beginning on January 1, 2014. The proposal will be available on  
1346 [www.MedicaidLTCManagedCare.dhw.idaho.gov](http://www.MedicaidLTCManagedCare.dhw.idaho.gov) in April. This proposal follows the direction in  
1347 the Idaho Legislature's House Bill 260, which asked for a plan for managed care for the dual  
1348 eligible population.

1349

1350 Idaho Medicaid currently offers a voluntary Medicare/Medicaid Coordinated Plan (MMCP)  
1351 under which Medicare benefits and some Medicaid benefits are coordinated by a managed care  
1352 entity. The current MMCP will be replaced by the new program, under which all dual eligibles  
1353 will receive all Medicare and all Medicaid benefits for which they are eligible through the health  
1354 plan. The goal is to ensure that all dual eligibles receive coordinated, effective health care  
1355 services.

1356

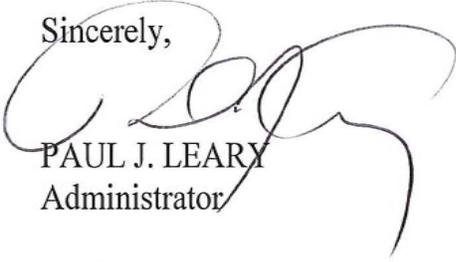
1357 Once CMS approves the proposal, Medicaid will work to replace the MMCP administrative rule  
1358 in the Idaho Administrative Procedure Act (IDAPA) §16.03.17, collaborate with the legislature  
1359 to revise Idaho Code §56-254, submit a 1915(b) waiver application, submit any needed waiver  
1360 amendment requests to existing waivers, and submit the State Plan Amendments (SPAs)  
1361 necessary to formally authorize the program.

1362

1363 Idaho Medicaid's development of the proposed program for dual eligible individuals will be  
1364 reviewed as part of the Policy Update at the next quarterly Tribal meeting on May 2, 2012.  
1365 Idaho Medicaid would like to receive your feedback about this change. Please contact Mark  
1366 Wasserman with comments, questions or suggestions at [wassermanm@dhw.idaho.gov](mailto:wassermanm@dhw.idaho.gov) or 208-  
1367 287-1156 prior to April 30, 2012.

1368

Sincerely,



PAUL J. LEARY  
Administrator

PJL/rs

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DRAFT

1376 **Attachment 11 - Enrollee Grievance and Appeal Process for Integrated Services**  
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1378 A. Contractor shall have a system in place for enrollees that includes a grievance process, an  
1379 appeal process and access to the Department's fair hearing system that complies with 42  
1380 C.F.R. 438 Subpart F, and allows any enrollee the opportunity to challenge Contractor's  
1381 actions related to any integrated service.  
1382

1383 B. Definitions. Contractor's policies and procedures shall define the following terms with  
1384 the following indicated meanings:  
1385

1386 1. *Action* means the denial or limited authorization of a requested service; termination,  
1387 suspension, or reduction of previously authorized service; the denial, in whole or in part,  
1388 of a payment for a service; or the failure to act upon a claim in a timely manner as that  
1389 term is defined in Section IV.

1390 2. *Appeal* means a request for review of an action.

1391 3. *Grievance* means an expression of dissatisfaction about any matter other than an  
1392 action. The term is also used to refer to the overall system that includes grievances, and  
1393 appeals handled at the Contractor level and access to the Department fair hearing process.  
1394 (Possible subjects for grievances include, but are not limited to, the quality of care or  
1395 services provided, and aspects of interpersonal relationships such as rudeness of a  
1396 provider or employee, or failure to respect the enrollee's rights.)

1397 4. *Notice* means a written Statement of the action the Contractor intends to take, the  
1398 reasons for the intended action, the enrollee's right to file an appeal, and the procedures  
1399 for exercising that right.  
1400

1401 C. General Requirements. Contractor's grievance and appeal system shall include the  
1402 following provisions:

1403 1. *Filing Procedures.*

1404 a. An enrollee may file a grievance or a Contractor level appeal.

1405 b. An enrollee may be represented by legal counsel at their own expense, or by a person  
1406 of the enrollee's choosing.

1407 c. The enrollee or the enrollee's representative may file a grievance or an appeal either  
1408 orally or in writing, either with the Department or with the Contractor. If filed with the  
1409 Department it will be forwarded to the Contractor.

1410 d. Unless the enrollee or the enrollee's representative requests expedited resolution, an  
1411 oral request for an appeal must be followed by a written request.

1412 2. *Timing.* A reasonable timeframe, no less than 20 days and not to exceed  
1413 28 days from the date of Contractor's action, for the enrollee or the enrollee's  
1414 representative to file a grievance or appeal.  
1415

1416 D. Notice of Action. Contractor's policies and procedures shall include the following  
1417 requirements for notifying enrollees and providers of actions the Contractor has taken or  
1418 intends to take:

1419 The notice must be in writing and must meet the language requirements of 42 CFR  
1420 438.10(c) and (d) to ensure ease of understanding.

1421 2. The notice must explain the following:

- 1422 a. The action the Contractor has taken or intends to take;  
1423 b. The reasons for the action;  
1424 c. The procedures for exercising Contractor level appeal rights;  
1425 d. The enrollee's right to represent themselves or be represented by a person of their  
1426 choosing;  
1427 e. The circumstances under which expedited resolution is available and how to request it;  
1428 f. The enrollee's right to have benefits continue pending resolution of the appeal, how to  
1429 request that benefits be continued, and the circumstances under which the enrollee may  
1430 be required to pay the costs of these service.  
1431 3. Contractor shall have procedures in place to ensure its notice of action is mailed within  
1432 the timeframes specified in 42 CFR 438.404(c).  
1433  
1434 E. Handling of Grievances and Appeals. Contractor's policies and procedures for handling  
1435 grievances and appeals shall include the following requirements:  
1436 Contractor shall give enrollees any reasonable assistance in completing forms and taking  
1437 other procedural steps including but not limited to providing interpreter services and toll-  
1438 free numbers that have adequate TTY/TTD and interpreter capability.  
1439 2. Contractor shall acknowledge receipt of each grievance and appeal.  
1440 3. Contractor shall ensure that individuals who make decisions on grievances and appeals  
1441 are individuals who:  
1442 a. Were not involved in any previous level of review or decision- making; and  
1443 b. If deciding any of the following, are health care professionals who have the appropriate  
1444 clinical expertise, as determined by the Department, in treating the enrollee's condition or  
1445 disease:  
1446 (1) An appeal of a denial that is based on medical necessity,  
1447 (2) A grievance regarding denial of expedited resolution of an appeal, or  
1448 (3) A grievance or appeal that involves clinical issues.  
1449 4. Contractor's process for appeals shall:  
1450 a. Provide that oral inquiries seeking to appeal an action are treated as appeals to establish  
1451 the earliest possible filing date, and shall be confirmed in writing unless the provider  
1452 requests expedited resolution.  
1453 b. Provide the enrollee a reasonable opportunity to present evidence, and allegations of  
1454 fact or law, in person as well as in writing.  
1455 c. Provide the enrollee and his or her representative opportunity, before and during the  
1456 appeals process, to examine the enrollee's case file, including medical records, and any  
1457 other documents and records considered during the appeals process.  
1458  
1459 F. Resolution and Notification.  
1460 Contractor shall dispose of each grievance and resolve each appeal, and provide notice as  
1461 expeditiously as the enrollee's health condition requires, and not exceed the following  
1462 timeframes:  
1463 a. *Grievances.* Disposition and notice to affected parties shall not exceed thirty (30) days  
1464 from the date the Contractor received the grievance.  
1465 b. *Contractor level appeals.* Disposition and notice to affected parties shall not exceed  
1466 thirty (30) days from the date the case is fully submitted for decision.  
1467 c. *Extension of timeframes.* Contractor may extend the timeframes from paragraphs a. and

- 1468 b. by up to fourteen (14) calendar days if:  
1469 (1) The enrollee requests the extension; or  
1470 (2) Contractor shows that there is a need for additional information and how the delay is  
1471 in the enrollee's interest.  
1472 d. *Requirements following extension.* If Contractor extends the timeframe, it shall give  
1473 the enrollee written notice of the reason for the delay.  
1474 2. Notice of grievance dispositions shall be provided to the affected parties in  
1475 writing stating at minimum:  
1476 a. A Statement of the grievance issue(s);  
1477 b. A summary of the facts asserted by each party;  
1478 c. Contractor's decision supported by a well-reasoned Statement that explains how the  
1479 decision was reached;  
1480 d. The date of the decision; and  
1481 e. An explanation of enrollee's right to file a Contractor level appeal including the  
1482 applicable timeframes and procedural steps.  
1483 3. For all appeals, Contractor shall provide written notice of the disposition  
1484 stating at minimum:  
1485 a. A Statement of the issue(s) on appeal;  
1486 b. A summary of the facts asserted by each party;  
1487 c. Contractor's decision supported by a well-reasoned Statement that explains how the  
1488 decision was reached; and  
1489 d. The date of the decision.  
1490 4. For appeals not resolved wholly in favor of the enrollee, Contractor's disposition  
1491 notice shall also include:  
1492 a. The right to request a State fair hearing, and how to do so;  
1493 b. The right to request to receive benefits while the hearing is pending, and how to make  
1494 the request; and  
1495 c. That the enrollee may be held liable for the cost of those benefits if the State fair  
1496 hearing decision upholds the Contractor's action.  
1497  
1498 G. Continuation of Benefits While Contractor Appeal and State Fair Hearing are Pending.  
1499 1. *Timely filing.* Contractor's policies and procedures shall define "timely filing" for  
1500 purposes of this section as on or before the later of the following:  
1501 a. Within ten days of the Contractor mailing the notice of action.  
1502 b. The intended effective date of the Contractor's proposed action.  
1503 2. *Continuation of benefits.* Contractor shall continue the enrollee's benefits if:  
1504 a. The enrollee or the enrollee's representative files the appeal timely;  
1505 b. The appeal involves the termination, suspension, or reduction of a previously  
1506 authorized course of treatment;  
1507 c. The services were ordered by an authorized provider;  
1508 d. The original period covered by the original authorization has not expired; and  
1509 e. The enrollee requests extension of benefits.  
1510 3. *Duration of continued or reinstated benefits.* If, at the enrollee's request, the  
1511 Contractor continues or reinstates the enrollee's benefits while the appeal is pending, the  
1512 benefits must be continued until one of the following occurs:  
1513 a. The enrollee withdraws the appeal.

1514 b. Ten days pass after the Contractor mails the notice, providing the resolution of the  
1515 appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has  
1516 requested a State fair hearing with continuation of benefits until a State fair hearing  
1517 decision is reached.

1518 c. A State fair hearing office issues a hearing decision adverse to the enrollee.

1519 d. The time period or service limits of a previously authorized service has been met.

1520 4. *Enrollee responsibility for services furnished while the appeal is pending.* Contractor  
1521 shall have a system in place to recover the cost of services furnished to the enrollee if the  
1522 final resolution of the appeal is adverse to the enrollee and benefits were continued  
1523 pending appeal to the extent they were continued solely by reason of this section.  
1524

1524

1525 H. Miscellaneous Requirements.

1526 1. *Information about the Grievance System.* Contractor shall provide the information  
1527 specified in this section about the grievance system to all providers and subcontractors at  
1528 the time they enter into a contract.

1529 2. *Recordkeeping and Reporting Requirements.* Contractor shall maintain records of  
1530 grievances and appeals and must review the information as part of the State quality  
1531 assurance.

1532 3. *Effect of Reversed Appeal Resolutions.*

1533 a. If the Contractor or the State fair hearing officer reverses a decision to deny, limit or  
1534 delay services that were not furnished while the appeal was pending, the Contractor shall  
1535 authorize or provide the disputed services promptly, and as expeditiously as the  
1536 enrollee's health condition requires.

1537 b. If the Contractor or the State fair hearing officer reverses a decision to deny  
1538 authorization of services, and the enrollee received the disputed services while the appeal  
1539 was pending, the Contractor must pay for those services, in accordance with State policy  
1540 and regulations.  
1541

1541