

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

***Draft Proposal for Public
Comment***

April 17, 2012

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

- To more effectively integrate the Medicare and Medicaid programs, CMS is partnering with states, health care providers, caregivers and beneficiaries to improve quality, reduce costs and improve the dual eligible beneficiary experience.
- Coordinated effort seeks to transcend boundaries and facilitate a national conversation with stakeholders to identify opportunities for alignment and improvement.

Draft Proposal

- The State of Idaho posted this proposal for a 30-day public comment period from April 13, 2012 to May 12, 2012 before submitting the proposal to the Centers for Medicare and Medicaid Services (CMS) by May 31, 2012 to CMS.
- Please send comments to LTCManagedCare@dhw.idaho.gov no later than 5:00 pm on May 12, 2012 or respond to the survey at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.

CMS' Three Part Aim

1. Enhance the quality of care Medicare and Medicaid beneficiaries receive;
2. Improve the health of the population; and
3. Lower costs through improvement.

Integrating Care for Dual Eligibles

- The majority of the dual eligible beneficiaries receive fragmented and poorly coordinated care.
- In an effort to make sure dual eligible beneficiaries have full access to seamless, high quality health care and to make the system as cost-effective as possible, the federal Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act.

Medicare-Medicaid Coordination Office Goals

- Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
- Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
- Improving the quality of health care and long-term services for dual eligible individuals.
- Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

Medicare-Medicaid Coordination Office Goals

- Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
- Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.
- Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
- Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

The Alignment Initiative

- The Alignment Initiative's goal is to more effectively integrate the Medicare and Medicaid programs.
- Partnering with States, health care providers, caregivers and beneficiaries, CMS will work to improve quality, reduce costs and improve the dual eligible beneficiary experience.
- Through the Alignment Initiative the Medicare-Medicaid Coordination Office seeks to transcend boundaries, facilitating a national conversation with stakeholders from around the country to identify opportunities for alignments and improve the two programs.

The Alignment Initiative

- As a first step in the Alignment Initiative, the Medicare-Medicaid Coordination Office compiled the Opportunities for Alignment List, which includes a broad range of content areas in which the Medicare and Medicaid programs have conflicting requirements or create incentives that prevent dual eligible beneficiaries from receiving seamless, high quality care.

Integrated Care for Dual Eligibles

- **Why focusing on Long Term Care?**
 - To decrease the confusion and fragmentation for these participants by developing a seamless coordinated care system
 - Long term services and supports represent the most challenging set of benefits with the least amount of managed care experience
- **Today's Forum**
 - Present draft proposal to support meaningful and robust stakeholder input and involvement regarding Medicaid Managed Care for Dual Eligible Beneficiaries

Proposal Outline

- A. Executive Summary
- B. Background
- C. Care Model Overview
- D. Stakeholder Engagement and Beneficiary Protections
- E. Financing and Payment
- F. Expected Outcomes
- G. Infrastructure and Implementation
- H. Feasibility and Sustainability
- I. Additional Documentation
- J. Interaction with Other HHS/CMS Initiatives
- K. Workplan/Timeline Template

A. Executive Summary

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

A. Executive Summary

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

A. Executive Summary

- Idaho intends to enter into a three-way, three-year contract with CMS and health plans (managed care organizations) to provide integrated, comprehensive, seamless coverage to dual eligibles.
- Contracts will require health plans to ensure that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-term supports and services) are provided, coordinated, and managed.

A. Executive Summary

- The participant will have:
 - Integrated set of benefits
 - One process for resolving disputes
 - One entity responsible for coordinating the high-quality, efficient care
 - A health home to support care management and coordination needs.

A. Executive Summary

- Contracts will include financial incentives to align the interests of health plans and participants.
- Health plans will maximize success by offering excellent care to beneficiaries.
- Payments to health plans will be blended capitation for Medicare and Medicaid services.
 - based on an actuarial analysis of historical costs and projected costs
- Payments will not change based on actual expenditures; rather on health plan quality measure performance.

A. Executive Summary

- Dual eligibles are currently able to opt into a Medicare-Medicaid Coordinated Plan (MMCP) made available under the authority of §1937 of the Social Security Act.
- MMCP covers and coordinates Medicare and many Medicaid services, and it will continue unchanged through the end of 2013.
- January 1, 2014, Idaho will replace the current MMCP with the new coordinated program.

A. Executive Summary

- The new MMCP will utilize mandatory enrollment into health plans under concurrent §1915(b)/ §1915(c) Social Security Act authority for Medicaid plan benefits.
- Effective way to ensure quality, coordinated care for all full dual eligibles in Idaho.
- Beneficiary choices and protections are a priority
 - Right to choose from at least two plans, change plans, self-direct care, choose from available providers within the plan's network, appeal health plan decisions, opt out of the Medicare component of the plan, etc.

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **Target Population**
 - All full benefit Medicare-Medicaid enrollees
- **Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide**
 - 17,219 – as of June 2011
- **Total Number of Beneficiaries Eligible for Demonstration**
 - 17,219 – as of June 2011
- **Geographic Service Area**
 - Statewide

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **Summary of Covered Medicaid Benefits through Coordinated Plans - 2014**
 - All Medicaid services will be available to qualifying participants including State Plan, Basic Plan, Enhanced Plan and HCBS waiver services based on their needs.
- **Financing Model**
 - Full Capitation
- **Proposed Implementation Date(s)**
 - January 1, 2014

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **HOSPITAL SERVICES:**
 - Inpatient
 - Outpatient
- **LONG-TERM CARE SERVICES:**
 - Nursing Facilities
 - Personal Care Services
 - Home Health
 - Aged and Disabled Waiver Services
 - Developmental Disability Waiver Services
- **PHARMACY SERVICES:**
 - Prescription Drugs; Medicare-covered drugs
 - Medicare Part D excluded drugs covered by Medicaid
- **MEDICAL SERVICES:**
 - Physician Services
 - Other Practitioners
 - Lab & Radiological Services
 - Federally Qualified Health Centers
 - Rural Health Clinics
 - Ambulatory Surgical Centers
 - Preventive Health Assistance
 - Family Planning
- **Emergency Room Services**
- **Therapy services**
- **Speech, hearing, and language services**
- **Medical equipment and supplies**
- **Prosthetic devices**
- **Specialized medical equipment and supplies**
- **DENTAL SERVICES**
- **DEVELOPMENTAL DISABILITY SERVICES**
 - DD Waiver Services (mentioned above)
 - ICF/ID Services
 - Dev. Disability Agency Services
- **VISION SERVICES**
- **MENTAL HEALTH SERVICES**
 - Inpatient psychiatric services
 - Outpatient mental health services
- **OTHER SERVICES**
 - Primary care case management
 - Indian Health Services
 - Medical Transportation

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- 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 – Medicaid Managed Care public forum held with panel presentations from hospitals, community health centers, and physicians.
- February 2012 – Managed care presentation to Idaho Senate and House Health & Welfare committee members
- 3/15/12 Proposal brief posted on website
- 4/13/12 – Draft proposal posted
- 4/17/12 – Statewide stakeholder videoconference on proposal
- 2012 – Personal Assistance Oversight (PAO) committee meetings, Medical Care Advisory Committee (MCAC) meetings, and Nursing Facility Prospective Payment System meetings

B. Background

- 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.

B. Background

- Dual eligibles account for just 21% of the Medicare population, but 36% of Medicare fee-for-service spending.
- Duals account for only 15% of the Medicaid population, but 39% of Medicaid spending.
- Medicare and Medicaid services are not coordinated for the large majority of dual eligibles in the State.

B. Background

- Idaho Medicaid currently offers a Medicare-Medicaid Coordinated Plan (MMCP) for dual eligible individuals offered by Blue Cross of Idaho.
- 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.

B. Background

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
- Indian health clinic services.

B. Background

- Care for duals 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 enrolled.
- Expenditure levels are likely to change, as only some Medicaid services are currently covered.
- As of June 2011, only 6% of duals were enrolled in the MMCP.

B. Background

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

B. Background

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

B. Background

- Primary care case management program, Healthy Connections, is offered to Medicaid participants.
- Healthy Connections is a program that health care services are provided through a single point of entry into the system, the person's primary care provider (PCP).
- PCP makes referrals to other providers when care is needed.
- Healthy Connections only applies to Medicaid services and does not coordinate Medicare services.

B. Background

- Starting in 2014, the coordinated care program will address the low MMCP participation by using a mandatory enrollment process into the new, coordinated health plans, under concurrent §1915(b)/§1915(c) Social Security Act authority.
- Duals currently in the MMCP will see improved, comprehensive care coordination in the new program.
- Idaho Medicaid will offer the full spectrum of Medicare and Medicaid benefits through coordinated health plan.

B. Background

- Current MMCP does not cover certain Medicaid waiver services, (long term care services, personal care services, psychosocial rehabilitation, and developmental disability services).
- In 2014, health plans will cover and coordinate all Medicaid and Medicare services.
- Participants will not necessarily receive any new benefits which are not already available to them, but the coordination of these benefits by one entity will enhance efficiency and improve the quality of care.
- Medicaid will encourage health plans to use their option to include additional benefits as a way to further improve quality and increase enrollment.

B. Background

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

B. Background

- By creating a coordinated system of care:
 - Cost-shifting will be reduced
 - Health plans nor Medicare nor Medicaid will benefit financially from shifting care to a setting which is not beneficial to the person
 - Health plans will receive the same reimbursement regardless of the setting where care is provided.
 - Medicare and Medicaid will be responsible for the same payments regardless of where services are delivered.
 - Health plan quality measure performance will impact what the health plans are paid to ensure decisions are based on what is best for the person.

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

C. Care Model Overview

Enrollment method(s)

- Mandatory enrollment will be implemented for the Medicaid component of the plan.
- Passive enrollment with an opt-out option for Medicare benefits.
- Outreach and education plan to be developed to inform participants of available plan enrollment options.
- Third-party, independent enrollment broker to facilitate communication and assistance for selecting the health plan.
- For participants already enrolled in a MMCP, but do not select a plan, they will remain with their current plan.

C. Care Model Overview

Available medical and supportive service providers

- Managed care providers will be required to ensure the availability of appropriate service providers who are proficient in meeting the needs of the dual eligible population, in accordance with Medicaid and Medicare requirements.

C. Care Model Overview

Proposed benefit design

- CMS, the State, and the health plans will agree to a three-way contract.
- Health plans will:
 - Receive capitated payments
 - Provide for coverage of the full spectrum of medically necessary Medicare and Medicaid services
 - Provide a single, cohesive set of benefits
 - Provide one benefit card to access services, rather than multiple cards.
 - Answer all questions regarding care
 - Handle all initial appeals.
 - Align Medicare and Medicaid services, and the associated policies and procedures so that the participant does not notice practical differences based on whether a service is available through Medicare or Medicaid.

C. Care Model Overview

Proposed benefit design

- The health plan will provide for care coordination by creating a care management team to implement principles associated with health home care model.
- The care management team will consist of a minimum of the participant, a care coordinator, and a primary care physician (PCP).
- The PCP is the anchor of the team, but additional team members/providers will be added as needed to coordinate and provide the full range of Medicare and Medicaid services through a multidisciplinary approach.
- The participant's role should be active.

C. Care Model Overview

Proposed benefit design

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

C. Care Model Overview

Proposed benefit design

- Develop a comprehensive, written plan of care.
- Update the care plan on an ongoing basis as appointments occur, tests are completed, medications change, transitions are made; goals are added or completed, etc.
- Provide comprehensive care coordination and management.
- Offer same-day appointments.
- Emphasize and implement principles of evidence-based practices, and offer/encourage preventive care.

C. Care Model Overview

Proposed benefit design

- Connect the participant with community-based resources when appropriate.
- Attempt to schedule a minimum of one annual appointment with the PCP annually, even if there are no immediate health concerns.
- Provide timely clinical advice by phone during office hours.
- Offer communication options by phone and email.
- Counsel at least 50% of patients/families to adopt specific, healthy behaviors.
- Provide educational resources for at least 50% of patients/families to assist in self-management.

C. Care Model Overview

Service Availability

- From the participant perspective, no services will be modified, added, or removed.
- The change is that all Medicaid and Medicare services will be coordinated through one health plan.
- Depending on which eligibility criteria are met, participants may currently be enrolled in the Medicaid Basic Plan, Enhanced Plan, Home and Community Based (HCBS) Waivers, or MMCP.

C. Care Model Overview

Service Availability

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

C. Care Model Overview

Evidence-based practices

- The State requires health plans to adopt practice standards based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
- The standards should be:
 - developed in consultation with contracting health care professionals
 - consistent with standards set forth by leading academic and national clinical organizations
 - based on enrollees the needs
 - reviewed and updated as appropriate
 - disseminated to all affected providers, and upon request, to enrollees and potential enrollees.
- The health plans will ensure utilization management, enrollee education, coverage of services, and other areas where applicable

C. Care Model Overview

Current Medicaid waivers/State plan services

- Basic plan
- Enhanced plan
- Two home and community based waivers
 - Aged and Disabled waiver and the Developmentally Disabled waiver include a variety of home and community-based services which help people to live in the community and avoid institutionalization.

C. Care Model Overview

Existing managed long-term care programs

- Idaho currently offers a Medicare-Medicaid Coordinated Plan (MMCP), which coordinates all Medicare services and many Medicaid services.
- The plan has shown promising results, but enrollment levels remain low due to the opt-in enrollment structure.
- Benefits excluded from the MMCP are now obtained through the Medicaid fee-for-service structure.

C. Care Model Overview

Existing managed long-term care programs

- The proposed model builds upon many of the same principles used in the existing MMCP.
- Additional outreach and educational efforts will be conducted to increase participation rates in the MMCP in 2013.
- In 2014, Idaho Medicaid will enroll all full dual eligibles into the health plans in order to ensure well-coordinated, high-quality care for Idaho's dual eligible individuals.

C. Care Model Overview

Existing specialty behavioral health plan

- In 2013, Medicaid participants will receive mental health benefits through a new, Statewide managed care plan. A Request for Proposal is being developed to take the next steps in the contracting process.
- Full dual eligibles enrolled in the mental health managed care program in 2013 will be transitioned out of that program and into a health plan for duals effective January 1, 2014.
- All health plans for duals will be required to offer the same mental health services provided in the mental health managed care program for all qualifying dual eligible participants.
- Health plans may provide these benefits by contracting with the same managed care entity providing mental health benefits or provide the same set benefits through other means.

C. Care Model Overview

Integrated programs via Medicare Advantage Special Need Plan (SNP)

- The existing Idaho Medicare-Medicaid Coordinated Plan is a Medicare Advantage Special Needs Plan (SNP).
- The MMCP plan will be replaced by this new program to integrate care for all full dual eligibles in 2014.
- Multiple health plans can participate in the new initiative – the State does not expect to limit the number of health plans.
- A minimum of two health plans will participate.

C. Care Model Overview

Other CMS payment/delivery initiatives or demonstrations

- All full dual eligibles will be linked to a primary care provider who will follow a health home approach. Idaho is also working to create a Medicaid State plan option to offer health homes for the following specific categories of individuals:
 - 1) A serious, persistent mental illness, or
 - 2) Diabetes and an additional condition, or
 - 3) Asthma and an additional condition.
- Exact implementation date is uncertain, but is slated for second half 2012.
- The new coordinated plans for dual eligibles will need to contract with the health homes to ensure that those benefits will be made available to all qualifying duals.

C. Care Model Overview

Other CMS payment/delivery initiatives or demonstrations

- Health homes are primary care practices which will provide comprehensive care management for the whole person.
- To qualify as a health home, specific requirements must be met.
- The health home model will provide care for an individual's physical condition, and provide links to long-term community care services and supports, social services, and family services.
- The health home program and this coordinated care program are natural fit, because both share the provision of seamless, efficient care as an important goal.
- Plans are required to contract with PCP's and care coordinators who will use health home principles for all participating dual eligibles who do not formally qualify for health home services.

D. *Stakeholder Engagement* and Beneficiary Protections

- Effective partnerships with internal and external stakeholders (participants, families, advocates, providers, health plans, etc.) is essential.
- Success will largely be contingent upon engagement and the capacity of health care and service providers that support and care for Medicare-Medicaid enrollees in their communities.
- Stakeholder input has been welcomed and encouraged throughout the development process.

D. *Stakeholder Engagement* and Beneficiary Protections

- A website is available to facilitate communication with stakeholders at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.
 - Website features include a summary of the history and status of the initiative, a survey through which suggestions can be offered, a feedback form which takes suggestions and questions, a brief of the proposal, links to panelist presentations at a Statewide stakeholder videoconference, information regarding upcoming events, and a number of helpful links.
- A Statewide videoconference was held with consumers, advocates, and providers on October 26, 2011.
 - A panel of six stakeholders presented their ideas and priorities for the design of a managed care system for dual eligible participants. Their PowerPoint presentations are available by clicking their names at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.
 - Many expressed hope in the promise of a well-designed program, while recognizing some potential challenges.

D. *Stakeholder Engagement* and Beneficiary Protections

- Second videoconference April 17, 2012.
 - The purpose is to gather feedback and suggestions, and make any needed changes before submitting the proposal to CMS.
- Further, stakeholders continue to have an opportunity to discuss issues for dual eligible individuals through the quarterly Personal Assistance Oversight (PAO) committee meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing Facility Prospective Payment System meetings.

D. *Stakeholder Engagement* and Beneficiary Protections

- Meetings with the potential health plans.
 - September 26, 2011 – five interested plans in attendance (Pacific Source, United Healthcare, Blue Cross of Idaho, Regence Blue Shield, and Sterling Plans). Topics included an overview of alignment initiative, current MMCP (strengths and weaknesses of that program from the perspective of the health plans and Medicaid, barriers to enrollment, strengths of the model and opportunities for improvement, health plan readiness to offer an integrated model, suggestions on how to make such a model a success were discussed.
 - The original target implementation date of January 1, 2013 was an aggressive timeline.
 - This feedback, along with similar feedback from other stakeholders, was significant in shaping the decision to move the target implementation date to January 1, 2014.

D. *Stakeholder Engagement* and Beneficiary Protections

- Feedback has been considered and incorporated regarding the importance of self-direction and payment structures that encourage the proper utilization of care.
 - A self-direction option must be offered by all participating health plans.
 - Health plans reimbursement will be tied to quality measures to ensure that appropriate care is provided.
 - Comments offered regarding challenges of covering services for the developmentally disabled population in 2014.
- Oregon and Utah presented their managed care experience to the Idaho Legislature on November 18, 2011.

D. *Stakeholder Engagement* and Beneficiary Protections

- A public forum on Medicaid managed care program was held on December 13, 2011.
- Managed care presentations were given to Idaho Senate committee members on February 16, 2012 and to Idaho House committee members February 24th.
- The Nursing Home Prospective Payment System meeting with skilled nursing and intermediate care facility providers on February 23, 2012.

D. Stakeholder Engagement and *Beneficiary Protections*

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

- Comprehensive enrollee handbook
- The beneficiary may choose health plan.
- The beneficiary may choose providers within plan's network.
- At least two health plans will be available to choose from.
- A participant may disenroll from a plan and enroll in a new health plan, effective the first of any month, if Medicaid is notified 15 days in advance.
- Beneficiaries must have an option to self-direct their care; they must be permitted to choose and change their direct care staff.

D. Stakeholder Engagement and *Beneficiary Protections*

- Participants may opt out of the plan for their Medicare benefits.
- Health plan will maintain a network of appropriate providers supported by written agreements.
- Health plan will maintain a network of appropriate providers sufficient to provide access to covered services.
- Health plan must work towards being certified by the National Committee for Quality Assurance (NCQA).

D. Stakeholder Engagement and *Beneficiary Protections*

- Health plans must ensure all beneficiary protections required in federal and State statutes and regulations for Medicare and Medicaid beneficiaries.
- Health plans will safeguard the privacy of health records and provide access to records upon request.
- Customer service representatives must be available for a minimum of 40 hours per week during standard business hours.

D. Stakeholder Engagement and *Beneficiary Protections*

- In establishing and maintaining its network of providers, health plans must consider the following:
 - The anticipated Medicaid enrollment;
 - The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented among enrollees;
 - The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
 - The numbers of network providers who are not accepting new Medicaid patients; and
 - The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

D. Stakeholder Engagement and *Beneficiary Protections*

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 to a phone line staffed by a nurse	Must be available at all times

D. Stakeholder Engagement and *Beneficiary Protections*

- **Nondiscrimination and Civil Rights:** The Contractors agree to comply with the following acts:
 - Title VI of Civil Rights Act of 1964 (Codified at 42 USC 2000 et. Seq.), 45 CFR Part 80
 - Title IX of the Education Amendments of 1972 (regarding education programs and activities);
 - Age Discrimination Act of 1975
 - Section V of the Rehabilitation Act of 1973
 - Title II of the Americans with Disabilities Act of 1990
 - Health Insurance Portability and Accountability Act of 1996 (codified at 42 USC §1320d et seq.)
 - All regulations and Administrative Rules established pursuant to the foregoing laws, and
 - 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.

D. Stakeholder Engagement and Beneficiary Protections - *Future Plans*

- Steps will continue to be taken to gather and incorporate stakeholder input.
- MCAC and PAO meetings.
- Nursing Facility Prospective Payment System meetings
- Survey and a feedback form are also available at:
<http://www.MedicaidLTCManagedCare.dhw.idaho.gov>
- The Department will continue to inform all parties as significant developments occur through
<http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.
- Participants outreach and education plan.
- Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs), and the 2-1-1 Idaho CareLine will also be utilized as communication partners.

D. Stakeholder Engagement and Beneficiary Protections - *Future Plans*

- The Department will make various resources available in order to provide interpreter and translation services to participants who are Limited English Proficient (LEP).
- The Department will provide access to over-the-phone interpretation, on-call interpretation, employee interpretation, oral translation, and translation services.
- The Department will provide reasonable accommodation to an applicant/participant with a qualified disability, which might include translating a document into Braille or providing it in large-print, or on tape.
- The Department's Civil Rights Manager is available to answer questions about providing such assistance.

E. Financing and Payment

Payment reforms and financial alignment model.

- The capitation financing model will be used in this initiative.
- Participating plans will receive a per member per month payment (PMPM) for each enrollee in exchange for delivering the integrated set of Medicare and Medicaid benefits.
- The exact amount of that payment will be based on an actuarial analysis of historical costs and anticipated savings resulting from the integration of services and improved care management.
- Contracting health plans will assume full risk for all required services for enrollees.

E. Financing and Payment

Payment reforms and financial alignment model

- Payments will be adjusted based on health plan performance with respect to pre-determined quality measures.
- Any savings from the program will be shared by Medicare and Medicaid in proportion to contributions made by the two programs.
- It is important and helpful from the State's perspective that any savings will be shared in this initiative, because most savings in integrated Medicare-Medicaid health plans are expected to be seen from reduced primary and acute costs, which are covered primarily by Medicare.

E. Financing and Payment

Critical steps in the rate development process include the following:

- The State provides summaries of monthly eligibility and claim experience for each MMCP enrollee on a PMPM basis to facilitate the analysis for the actuarial rate certification.
- The summary will be based on the claims detail for the 36-month period of 7/1/2008 – 6/30/2011. The detailed claims data will be summarized by service category and membership months for each of the counties and populations of dual and non-dual beneficiaries. The data is then mapped into rate categories.
- Base experience will include all services to be covered by the health plan.
- The cost projections include adjustments for trend, health care management, selection and health plan administrative costs.

E. Financing and Payment

Critical steps in the rate development process include the following:

- The cost projections include adjustments for trend, health care management, selection and health plan administrative costs.
- The Medicaid capitation payment does not include physician incentive payments.
- The Contractor must comply with all requirements and limitations set forth in 42 CFR § 422.208 and 42 CFR § 422.210.
- The Contractor must submit a report to the Department quarterly which summarizes all incentive payments made. The report shall include what the incentive payment was for and the amount of the incentive payment.
- The Contractor shall provide to enrollees, upon request, physician incentive payment program information.

F. Expected Outcomes

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

- The State will require the health plans to monitor, collect, and track data on key cost and quality metrics, including beneficiary experience, access to and quality of all services, utilization, etc.
- The State will conduct surveys and pull claims data to determine financial trends. (provider/beneficiary ratios, decreases in hospitalizations, wait times for appointments, percent of individuals receiving yearly visits to their primary care physicians, percent of individuals receiving preventive care, etc.)
- A detailed set of metrics will be developed and included in the three-way contracts.

F. Expected Outcomes

- Potential improvement targets for quality measures
 - The size of the network of appropriate providers
 - The numbers of network providers who are accepting new Medicaid patients
 - The number of beneficiaries
 - The provider/beneficiary ratio
 - Number of hospitalizations
 - Wait times for appointments
 - Number of skilled nursing facility admissions
- The State will work with stakeholders to develop specific numerical targets and measures to ensure that appropriate standards are in place to ensure a high quality of care.

F. Expected Outcomes

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

G. Infrastructure and Implementation

Idaho is prepared to devote the necessary staff to ensure the initiative is successful.

- 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

G. Infrastructure and Implementation

- Idaho Medicaid to provide CMS any needed data upon request, including expenditure and encounter data.
- Idaho Medicaid also intends to use the process CMS has made available in order to access timely Medicare Parts A and B claims data and D event data, and Medicare Parts A, B, C, and D eligibility and enrollment data
- Idaho Medicaid has developed a project plan and timeline that list the steps that must be taken to achieve implementation.
- House Bill 260
- Cost report data

H. Feasibility and Sustainability

Potential barriers/challenges:

- Statutory and regulatory changes will be required to implement the proposal.
- Implementation is also dependent on finding an absolute minimum of two health plans willing and capable of participation.
- Collaboration with the health plans and stakeholders in efforts to create the most effective program possible.
- Sufficient numbers of providers in all service areas
 - However, there are large numbers of providers and a wide variety of facilities and provider types available to provide good access to care for the dual eligible population.

H. Feasibility and Sustainability

Significant statutory and/or regulatory changes:

- IDAPA §16.03.17, the section containing the current MMCP §1937 benefits plan, will need to be replaced by 2014.
- Minor revisions will also be needed to IDAPA §16.03.09 and IDAPA §16.03.10.
- Statutory revision in Idaho Code §56-254 due to the MMCP §1937 benefits plan being replaced.

H. Feasibility and Sustainability

New State funding commitments or contracting processes needed:

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

H. Feasibility and Sustainability

Scalability and replicability in other settings/States:

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

H. Feasibility and Sustainability

Letters of support

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

I. Additional Documentation

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

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

J. Interaction with Other HHS/CMS Initiatives

- Idaho intends to use the demonstration for dual eligibles as an additional way of identifying individuals who would be appropriate for the Idaho Home Choice - Money Follows the Person program, which allows individuals to move from institutional settings into the community. Within one year from the time of an individual's enrollment, the health plan will evaluate that person's suitability for the program, based on the following requirements:
 - A participant must have been in a Nursing Facility, Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID), or an Institution for Mental Disease (IMD) for a minimum of 90 days (excluding any Medicare Part A days);
 - A participant must wish to move out of the institution and into a community setting; and
 - A participant must be Medicaid-eligible at the time of discharge and a resident of Idaho (these requirements should always be met if an individual participates in the coordinated plan for dual eligibles).

J. Interaction with Other HHS/CMS Initiatives

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

J. Interaction with Other HHS/CMS Initiatives

- CMS' *Reducing Avoidable Hospitalizations Among Nursing Home Residents* initiative also fits well with this demonstration.
 - CMS research has indicated that 45% of hospital admissions for those receiving Medicaid nursing facility services are preventable.
 - Principles being implemented in this proposal, such as care coordination, transition planning, preventive care and evidence-based practices are principles that should help to reduce avoidable hospitalizations in the nursing home setting.
- This initiative should help to further the goals of the *Million Hearts* initiative.
 - While the care integration effort is not directly connected to *Million Hearts*, better care coordination and a greater emphasis on prevention should help reduce heart attacks and strokes.
 - From a broader perspective, better monitoring of a wide variety of risk factors for many health problems should be in place with the participation of the managed care health plans in 2014.

Proposal Feedback

- Email

[*LTCmanagedcare@dhw.idaho.gov*](mailto:LTCmanagedcare@dhw.idaho.gov)

- Website

[*http://www.MedicaidLTCManagedCare.dhw.idaho.gov*](http://www.MedicaidLTCManagedCare.dhw.idaho.gov)

- Survey

[*http://www.MedicaidLTCManagedCare.dhw.idaho.gov*](http://www.MedicaidLTCManagedCare.dhw.idaho.gov)