

Idaho Medicare-Medicaid Coordinated Plan Demonstration Proposal Brief

Introduction

This document provides a synopsis of Idaho's design for the Federal-State initiative to integrate care for people who are dually enrolled in Medicare and Medicaid. Stakeholders are asked to submit feedback about this synopsis to LTCManagedCare@dhw.idaho.gov. Feedback will be considered and used as the details of the proposal to the Centers for Medicare and Medicaid Services (CMS) are finalized in April.

Background

- The dual eligible population includes people who are eligible for both Medicare and Medicaid.
- Commonly referred to as "dual eligibles," these individuals are among the nation's most chronically ill and costly individuals.
- Most dual eligibles, including the 20,000 dual eligibles in Idaho, receive fragmented, poorly coordinated, and disproportionately expensive care as they attempt to navigate through the complexities of the Medicare and Medicaid systems.
- Idaho Medicaid currently offers a broad array of services through several benefit plans, including the Basic Plan, Enhanced Plan, Home and Community Based (HCBS) Waivers and Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals.
 - However, a holistic, comprehensive approach to coordinating these extensive Medicaid services is missing.
 - Except for MMCP participants, who have many but not all of their services coordinated, most dual eligibles do not receive any care coordination of Medicaid and Medicare services.
- Duals in the MMCP receive better-coordinated, cost-effective care, but only 6% of Idaho dual eligibles are currently enrolled.
- To address the issue of poorly coordinated care for most duals, and to comply with the Legislature's mandate to develop a managed care approach to services for dual eligibles, Idaho Medicaid will participate in a demonstration that will offer the full spectrum of Medicare and Medicaid benefits to duals starting January 2014.

Proposal Overview

- Idaho Medicaid, CMS, and selected health plans will enter into three-party contracts to provide integrated, coordinated care for dual eligibles.
- Beginning on 1/1/2014, Idaho full-benefit dual eligibles will enroll in a selected health plan that will coordinate all Medicaid and Medicare benefits.
- The health plan will be the single point of contact and accountability to:
 - Develop and offer a strong network of providers;
 - Help dual eligibles understand the benefits offered;
 - Answer duals' questions regarding all aspects of their care;
 - Resolve appeals and grievances (if not resolved satisfactorily, dual eligibles retain the right to request a state hearing);
 - Pay providers for services rendered; and
 - Provide for the coordination of all Medicare and Medicaid services in a seamless manner.
- The contracts will offer the health plans a per-member-per-month (PMPM) payment.
 - The contracts will build in financial incentives which align the interests of the beneficiaries and the health plans.
 - Payments will be adjusted based on health plan performance with respect to quality measures.

- Payments to health plans will be blended capitation payments.
- Stakeholder involvement has been, and will continue, to be encouraged to assist Idaho to develop the best possible program.

Care Model

- Plans will coordinate the full range of services for all full-benefit dual eligibles statewide.
- Each individual in the plan will be assigned a case manager who will assist in coordinating the full range of services.
- The case manager will coordinate care with all providers and facilities, assist with discharge planning, manage care for those with complex medical needs, and facilitate transitions between institutional and community settings.
- Individuals will continue to be eligible for the Medicaid Basic Plan, Enhanced Plan, or waiver services depending on which set of benefits they qualify for.
- Health plans may offer additional benefits as a way to increase quality and compete for higher enrollment.
- Health plans must adopt standards based on evidence-based practices.

Stakeholder Engagement

- Two websites were created to provide stakeholders with information and an opportunity to provide feedback:
 - www.MedicaidLTCManagedCare.dhw.idaho.gov
 - www.MedicaidManagedCare.dhw.idaho.gov
- A statewide stakeholder conference was held in October, and another is planned for April.
- Reports are made to the Personal Assistance Oversight Committee and the Medical Care Advisory Committee on a regular basis.
- Feedback is welcomed and encouraged through the website forms or direct email: LTCManagedCare@dhw.idaho.gov.

Beneficiary Choice and Protections

- Beneficiary choice is a key priority and will be fostered and preserved via a number of provisions, which include:
 - An option to self-direct care will be a feature of all participating health plans
 - Beneficiaries may choose and change their direct care staff
 - A minimum of two plans will be available to select from
 - Beneficiaries may choose which plan to enroll in
 - Beneficiaries will have the opportunity to disenroll from their plans and enroll new health plans, effective the first of any month, if requested at least fifteen (15) days in advance.
 - Beneficiaries may opt out of the plan for Medicare benefits.
 - Health plans must comply with beneficiary protection requirements specified in all applicable federal and state laws for the Medicare and Medicaid programs.
- Health plans will be paid more if they reach specified quality measures, and less if they do not meet the quality measures.
- Health plans will provide beneficiaries 24-Hour access via telephone, which will be staffed by a nurse.
- To challenge any reduction or denial of benefits, an appeal may be made to the health plan, which is required to administer a unified appeals process.
- If the health plan makes an unfavorable ruling, the beneficiary may request a hearing through existing Administrative Procedures.

- To assist with ensuring network adequacy and promoting continuity of care, health plans will be expected to contract with existing Medicaid providers who choose to participate in the plan that meet the plan's provider qualifications..

Financing and Payment

- The capitation model of financing has been selected
- The health plans will receive a PMPM payment based primarily on an actuarial analysis of historical claims data.
 - In return for the PMPM payment, the health plans will pay providers to cover all Medicare and Medicaid benefits the individual qualifies for.
 - The incentive for different payers to shift costs will be eliminated since the health plan will be the sole payer.
- Quality measures must be met for the health plans to receive the maximum payment, thereby aligning the health plans' interests with the beneficiaries' interests for quality health care.
- Medicare and Medicaid will share in any cost savings.

Expected Outcomes

- Better-coordinated care from the most appropriate provider type in the most appropriate setting.
- Improved health outcomes.
- Services provided in a more cost-effective manner.
- Beneficiaries should have access to providers in all necessary specialties.
- The provider/beneficiary ratio should allow for care to be provided within reasonable timeframes.
- Decreased number of hospitalizations based upon a reduction in unnecessary hospitalizations, due to well-coordinated care.
- Decreased number of skilled nursing facility admissions due to care coordination.
- Increased utilization of home and community based services.

Feasibility and Sustainability

- Implementation will require an approval of a 1915(b) waiver, which will be administered concurrently with the 1915(c) waiver.
- Regulatory and statutory changes will be necessary, but since this initiative aligns with the direction of House Bill 260, these changes should not be problematic.
- This initiative is a partnership and would not be possible without participation and support from key groups. Letters of support from four insurers, the Governor's office, and the Idaho Commission on Aging are indicative of support from a variety of groups.

Interaction with other Initiatives

- *Idaho Home Choice*: Within a year of enrollment, the provider will evaluate all beneficiaries to determine whether they qualify for the Idaho Home Choice program, which helps individuals move from institutions into the community.
- *Idaho Medical Home Collaborative*: Idaho intends to begin offering health homes, where care is coordinated by a primary care practice for individuals with multiple chronic conditions, by July 2012. Health plans will be required to contract with the health homes. The health home initiative and this initiative share the goal of providing efficient, seamless, coordinated care.

Work Plan/Timeline Template

| Planned Completion Date/Status | Key Activities/Milestones | Responsible Party/Parties |
|---------------------------------------|---|----------------------------------|
| April/May 2012 | Submit proposal to CMS and post for public comment (minimum of 30 days). | State |
| May 2012 to April 2013 | <ul style="list-style-type: none"> • State identifies and works on making needed statutory and regulatory changes • State refines timelines and task plans • Plans assess what they will need to do to participate, decide whether they will participate, and develop plan for how they will comply with requirements • State, CMS, and Insurers continue collaboration | Insurers/CMS/ State |
| April 2013 | Interested plans must submit an electronic Notice of Intent to Apply to CMS. | Insurers |
| May to early July 2013 | Health plans selected through a joint CMS-state selection process. Interested organizations submit required information, including licensure, network adequacy, and plan model of care. CMS and state will review and select plans. | CMS/State |
| June 2013 | Submission of proposed benefit packages to CMS. | Insurers |
| Summer 2013 to Fall 2013 | Sign Memorandum of Understanding (MOU) with CMS. | CMS/State |
| July 2013 to September 2013 | <ul style="list-style-type: none"> • Readiness review for participating plans • Contract negotiations with participating plans | Insurers/CMS/ State |
| July 2013 | Demonstration plan selection completed. | CMS/State |
| September 2013 | Sign three-way contracts. | Insurers/CMS/ State |
| October 2013 to December 2013 | Medicare Advantage and Part D Annual Coordinated Election Period. | Insurers/CMS/ Beneficiaries |
| December 2013 | <ul style="list-style-type: none"> • Legal notice of State Plan Amendment (if SPA is needed) • Submit SPA (if SPA is needed) to CMS | State |
| January 2014 | Implement, monitor, and evaluate | Insurers/State |