Appendix 3: Payment and Operational Waivers, Requests and Recommendations

Appendix 3: Variances and Waivers Requested

While the State expects to be able to operate the demonstration within the parameters proposed by CMS in the January 29, 2012 guidance, that document did not include operational detail that may be necessary for implementation. The State provides the following list of items in which clarification may be needed during the implementation process on items already discussed, or in which waivers or variances from Medicaid managed care or Medicare Advantage procedures may be necessary. Most of these items are also noted in the proposal. Since we cannot anticipate all of the details absent more detailed discussions or guidance from CMS, this list may change as additional information becomes available.

H Numbers

1. The State appreciates CMS response to our request that demonstration plans also offering SNBC for people with disabilities be allowed to have separate H numbers for that product. We provide this rationale for why those H numbers are needed for CMS reference. SNBC has certain design features developed in conjunction with an active disability stakeholder oversight group based in state statutes which has strongly advocated for a disability specific focus for SNBC. In keeping with the need to separate oversight and reporting requirements for the two programs, the plans have had separate H numbers for the two products since SNBC began in 2008. While separate products may also be accommodated through the use of additional Plan Benefit Packages (PBPs) the State understands that many reporting and operational requirements are consolidated at the H number level, not the PBP level. Therefore separate H numbers would still be required for certain oversight and performance reporting in order to track and maintain differences related to the needs of each population.

Network Adequacy

1. The State requests that CMS deem existing D-SNP and MCO networks without resubmission of detailed HSD tables and contracting templates under the demonstration as part of the MMICO transition. The State and CMS have already approved the existing networks, CMS has accepted the current contracting templates and the State lacks the resources to re-review them. In addition, it is not clear how CMS automated review procedures will reflect provider availability and community standards in rural areas of the state. If current provider service patterns are not well reflected, a very large number of exceptions may result, creating unreasonable work load and burdens on CMS, the State and the plans for special review processes. Details on the CMS proposed exceptions review process have not yet been made available further limiting the time remaining for submission. In addition, detailed information must be collected and submitted on each provider including admitting privileges to hospitals, number of SNF beds, contract template cross references to Medicare authorities, and names of those authorized to sign contracts. If deeming is not acceptable, the State requests that the deadline time allowed for submission of these additional details be extended and that contract templates be submitted along with final signature pages which are due in the fall. Under current requirements that would remain in place, significant network changes (including changes in primary care physicians and also nurse practitioners) would continue to be reported to the State and CMS as well as to affected enrollees.

Model of Care (MOC)

1. Deeming of Existing Submissions: As discussed with CMS, the State requests that CMS deem current MOC submitted by MSHO D-SNPs as meeting the demonstration's standards without requiring that current MOCs be re-viewed and scored. These MOC have already been approved by CMS and already reflect integrated care management policies consistent with State policy. The State is not proposing any immediate changes in its MOC policy at this time. Seven of eight participating demonstration plans have received three year approvals with one plan receiving a two year approval.

CMS has not yet made details of any new review process under the demonstration. There are many implications involved in the re-review of these MOCs since re-review could result in different scoring and/or raise issues for the State's current care coordination and long term care policies.

2. Multiple year Approvals: the State requests that current multi-year approvals be accepted under the demonstration.
3. If the State and CMS cannot reach agreement on demonstration implementation, the State requests that the current MOCs and multi-year approval status be retained for a transition back to D-SNP status.

Medicaid Formularies

1. The State requests that CMS accept current coordinated benefit determinations used by Minnesota D-SNPs in lieu of submission of all Medicaid drugs as Part D formulary supplements until such time that supplementary submissions can be made. Submission of the Medicaid formularies will take additional time because of the need for new PBM file formats and CMS policy changes for benzodiazepines and barbiturates which will result in new and complex Medicaid coverage policies for continued use of these under certain circumstances. The State is concerned that there is a lack of time for the State to develop and issue guidelines to the demonstration plans on the resultant Medicaid formulary changes prior to the required submission date.

Enrollment

1. Seamless Transition for Current MSHO and SNBC Medicare D-SNP Enrollees: The State requests that current D-SNP enrollees be seamlessly transitioned to the new demonstration in order to preserve their current primary care, care coordination, and Part D arrangements without disruption. The State and the MMICO (or the State, MMICO and CMS) would send each member a joint notice stating that their current health plan is transitioning to the demonstration's operational authority and that they do not need to take any action to remain in their health plan with continued Medicare and Medicaid services.
2. TPA Enrollment Function: The State requests to retain its current centralized enrollment function in which the State conducts enrollment functions for both Medicare and Medicaid acting on behalf of both the State and the health plans. Under this process enrollments would be conducted by the State. In addition, enrollment through Medicare.gov would not be allowed because it is not able to coordinate with the State's Medicaid enrollment system.
3. Opt Out Enrollment: The State requests that current and new MSC+ enrollees be enrolled in the demonstration after being given the option to opt out and remain in MSC+. Those who have opted out would be notified once each year at open enrollment of the opportunity to change their minds and enroll, however members would not be restricted from choosing to enroll at any time during the year. A similar policy would be followed for SNBC enrollees. Newly eligible enrollees for both groups would continue to be provided with opt out choices on a quarterly basis. The State may need to request additional adjustments once more information about opt out and enrollment processes is available.
4. Transition Policy: The State requests to retain the current SNP policy of allowing up to six months (in our case up to 90 days) of enrollment in the demonstration plan for member who have lost dual status so that they can transition to a new Part D plan. Many members lose Medicaid eligibility temporarily due to paper work issues but most are reinstated within 60-90 days. Currently these members stay in the plan for Medicare for up to 90 days, Medicaid ceases payment, plans continue services, and when eligibility is regained retroactively plan payments are also reinstated retroactively. If eligibility is not reinstated, members are disenrolled and there is no additional payment made to the plan. This

preserves continuity for the member and allows time to seek alternative Part D coverage for those who lose eligibility permanently.

5. Turning 65: The State requests that SNBC enrollees who turn 65 are allowed to remain in SNBC if they so choose (as is current policy), in order to preserve continuity of their care arrangements as under the current arrangement for D-SNPs.

Appeals and Grievances

1. Integrated Appeals Process: the State requests that it be allowed to follow its long standing integrated appeals process as outlined in Appendix 2. This process has been reviewed by CMS Medicare many times and we understand it to meet all Medicare requirements with the exception of a slight difference in Medicare timelines which should now be acceptable under the demonstration's announced parameters.
2. Language complexity: When integrating Medicare and Medicaid benefits, the current required DTR notice combining all Medicaid requirements with Medicare requirements gets very long. The State requests to work with the MMICOs and CMS to propose a shorter less confusing notice that retains all information members need for appeals.
3. Reporting of Appeals and Grievances: To the extent that there are separate requirements for reporting of grievances and appeals under current Part C reporting, the State requests that consolidation of this reporting be considered. Many Medicare and Medicaid services overlap. The State already collects extensive information about denials, terminations and reductions of service including grievances and appeals which could be shared with CMS.

Marketing/Beneficiary Information

1. Materials Review Process: The State requests that one centralized reviewer at the CO be assigned to approve materials for all dual demo participants to assure consistency and facilitate coordination of efficient reviews. In addition, the State requests that it determine which materials may be submitted as State approved models with file and use options, and when a State submitted model is used to reduce the timeline for to 10 days instead of 45.
2. Language: The State requests that CMS defer Medicare language block requirements to the State. New Medicare SNP requirements exclude five of the most used languages in Minnesota such as Somali and Hmong, but include other languages not relevant to this area of the country so would not meet the needs of our enrollees.
3. Currently Approved Materials: The State requests that currently approved materials under D-SNP "H" numbers be moved to new demonstration plan "H" numbers if necessary. In the meantime, the State along with the D-SNP workgroup will facilitate a review process to determine which if any materials must be modified and the timelines for such modifications as well as how such current approved model materials will be revised for the demonstration.
4. EOC/ANOC: The State requests that Medicaid information be integrated into the EOC using a model document developed by State and approved by CMS. However, due to the timing of legislative changes, the State may not be able to provide the detail of Medicaid benefits and policy changes in time for the October 1 deadline. For the same reason the State has not been able to include Medicaid information in the ANOC, so the State sends a separate notice of all Medicaid changes. The State proposes that the two documents remain separate unless timelines can be changed or a new process is worked out under the demonstration.
5. Skilled Nursing Facility Denials: The State requests that standardized forms currently required by Medicare for skilled nursing denials not be used under this demonstration. These forms indicate that the health plan will no longer pay, which is not true if the health plan is able to pay under the

Medicaid benefit set, and this is upsetting and confusing to the enrollee. The State proposes that an integrated form be developed as a model document for use by all Minnesota demonstration plans.

6. Part D materials: Currently there is no clear process for altering or adapting Part D materials for integrated programs to make them accurate for dual eligibles. The State requests that it be allowed to work with the MMICOs to determine which materials need modification and to propose such modifications (including information about Medicaid formulary wrap arounds) for approval by the CMS RO.

Oversight, Monitoring, Reporting and Auditing

The State requests that CMS use this opportunity to streamline and consolidate oversight and monitoring of integrated Medicare/Medicaid managed care programs. As part of the MOU process the State proposes to work with CMS on details of this plan. Elements that should be considered at minimum are listed below.

- HOS: Since the State already requires the MCO to collect ADL and IADL data on enrollees and submit it to the State there is little value to having to conduct the HOS self-survey unless it is used for frailty factor purposes. The State requests that the HOS not be required under the demonstration unless the frailty factor is provided.
- Part C Reporting: The State requests that Part C reporting requirements not be applied to integrated demonstration programs or be substantially revised to ensure efficiency and alignment of requirements under both programs. Current reporting excludes Medicaid services so would not give a clear picture. In particular, the State would like to remove the Health Risk Assessment reporting process from these Part C requirements and integrate it with other State assessment reporting requirements. (See item 6 below). In addition, the State would like to explore whether demonstration plan hiring of independent data evaluators is still required under an integrated reporting system.
- Duplication of Medicare and Medicaid CAHPS: The State requests that the CAHPs requirement be combined for Medicare and Medicaid. The State conducts CAHPs at a more detailed program level than the CMS requirement and also includes additional questions on care coordination, so the State proposes to utilize its CAHPs in place of the CMS required CAHPs.
- HEDIS: Currently DHS collects and performs HEDIS analyses for all participating plans and reports this information publicly. In addition, each plan must report a set of HEDIS measures to the State licensing agency, the Minnesota Department of Health ,which also produces a report and submits information to NCQA. CMS also requires that HEDIS measures be collected. While DHS and MDH attempt to coordinate their HEDIS requirements with CMS requirements, these reporting requirements could be better aligned. The State proposes to work with CMS to consolidate reporting of HEDIS reporting in the most efficient manner.
- QIPs, CCIPs and PIPS: The State requests that PIPs, CCIPs and QIPs be combined under the demonstration. However the State wants to have a role in proposing and reviewing topics and results. Topics must leave room for State priorities such as issues specific to seniors (average age 80) including those with long term care needs as well as others which may be more relevant to people with disabilities and /or mental and chemical health conditions.
- CMS Audits: CMS should develop separate audit guides for the demonstration which should be specific to dual eligibles and different from those for regular SNPs and MA plans. States should be consulted on these guides and involved in the auditing process.
- Structure and Process Measures: The State requests clarification on the role of SNP Structure and Process Measures under the demonstration. Many of the S&P reporting requirements duplicate or overlap those in the MOC as well as some of the QIP and CCIP requirements. The State suggests that

these overlapping requirements could be consolidated under the demonstration and proposes to work with CMS during the MOU development on a streamlined process.

- Health Risk Assessment (HRA) and Transitions of Care Reporting: Reporting for these important elements is fragmented between CMS and the State, creating additional administrative complexity and barriers to measurement of outcomes. As part of the effort in item 6 above, the State proposes to review the Health Risk Assessment and Transitions of Care reporting processes and develop a plan to integrate them with current State reporting processes including links to reporting for long term care assessment and transitions from nursing homes under the State Money Follows the Person Demonstration.
- Performance Measures: The State requests that all performance measures to be applied to participating demonstration plans be reviewed and consolidated. A clear measurement template outlining all requirements should be developed that includes both Medicare and Medicaid priorities at both the CMS and State levels. There are so many measures to which the demonstration may be subject and such a lack of clarity over the role of the various measures that little sense can be made of the current measurement requirements. These include HEDIS and CAHPs, other current Medicare Advantage measures, specific SNP measures, Star Rating measures, current and potential CMS and State Medicaid long term care measures, CMS and State Medicaid managed care measures, new measures being proposed for dual eligibles by NQF and NCQA, evaluation measures being proposed by the evaluators, and countless additional measures in use specific to disease conditions or initiatives for reducing avoidable hospitalizations and improving care, many of which overlap and are duplicative.

Encounter Data Reporting

1. The State requests that CMS rely on the State's integrated encounter data reporting system for demonstration processes rather than creating a second encounter data reporting system for Medicare services. Since the State already collects all Medicaid and Medicare encounters, the State proposes to share its encounter data with CMS rather than having the MMICOs have to submit data to two different entities in two different formats. However, we understand that direct submission of Part D encounters to CMS would still be required.
2. Encounters should not have to be reported separately for Medicare and Medicaid services and reporting should be integrated.

Financing and Payments

1. The State has requested clarification from CMS on how Medicare baselines for savings scenarios and rates will be established. These clarifications and arrival at a viable Medicare/Medicaid financing model will be needed before contracts with MMICOs can move forward.
2. Withholds: DHS requests that performance based withholds under the demonstration be aligned with existing Medicaid withholds to the extent possible within current statutes with any new measures to be determined under the three-way contracting process.
3. HCC Risk Adjustment Model Improvements: The State requests that CMS apply proposed Medicare HCC risk model improvements to the demonstration, including the proposed change for dementia and the increase in number of conditions considered under the HCC model, both of which MedPAC has already recommended to Congress for implementation.
4. Risk/Gain Corridors: The State now includes a risk and gain sharing corridor arrangement in all SNBC contracts for non-SNP enrollees including dual eligibles. This mechanism is carefully designed to protect the State as well as the MCO. (See Section 4.1.2 of the SNBC contract.) We request that

CMS apply this risk and gain sharing plan to the entire integrated rate setting process for all people with disabilities enrolled under this demonstration.

5. CDPS for People with Disabilities: The State requests that CMS consider utilizing the CDPS risk adjustment model for both Medicare and Medicaid services for this population. The CDPS risk adjustment model is specifically designed for people with disabilities and has a more inclusive diagnostic algorithm than CMS' current Medicare risk adjustment system. The State is considering rebasing CDPS weights so CMS could work with the State to assure that weights are appropriate for both Medicare and Medicaid services. If the State's CDPS system is not utilized, the State requests that CMS implement the expanded diagnoses described above along with the new enrollee Medicare HCC risk model improvement which was found to be important for C-SNPs as studied by the General Accounting Office.

Supplemental Benefits

1. The State requests that it not be limited to current SNP policy outlined in the April 2 call letter regarding supplemental benefits. The benefits outlined there would be of no benefit to Minnesota, since all are currently covered by Medicaid. The State has already proposed one additional Medicare benefit (health care home) under the demonstration but the State does not consider that a "supplemental benefit" since it is within the scope of current primary care responsibilities as modified by already allowed payment reforms and best practices. The State and MMICOs will negotiate any additional supplemental benefit to be provided under the demonstration with CMS review.

Procurement

1. The State proposes to certify existing MSHO D-SNP sponsors as eligible participants under the demonstration for initial implementation. All MSHO plan sponsors already have been approved by CMS as SNPs and meet federal and State requirements to provide services. The State also intends to certify existing SNBC plans as eligible participants. However the State is required to conduct a periodic procurement of all products, and SNBC re-procurement is scheduled for later in 2012. The State will coordinate this SNBC procurement and the demonstration certification process with CMS for implementation for people with disabilities in the second phase of the demonstration.

Transition to SNP Status

1. The State requests assurances from CMS that it would facilitate transitions of demonstration plans back to D-SNP status to avoid disruptions in long standing integrated care arrangements for beneficiaries in the event that there is agreement among all parties that the demonstration is not viable.