

Appendix 6: Comments and Letters of Support for this Proposal

Appendix 6. Summary of Public Comments

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I. Minnesota Design Proposal: Summary of Public Comments and Responses:

1. The State’s Draft Proposal was published March 19 for a 31 day comment period ending April 19. A special email address was created for comments: dualdemo@state.mn.us.
2. In addition to the letter of support from Governor Mark Dayton, the State received 26 separate letters of support or comment submitted by 22 commenters. (Four sent both a letter of support and a comment letter.)
3. Seventeen letters expressed support. Eight of the commenters had mainly comments but did not state that they opposed the demonstration. Only one commenter stated opposition to the demonstration. All comments were insightful and constructive.
4. All letters of support and comments have been enclosed in this Appendix for CMS review. Because many letters combined support for the proposal with comments for both the State and CMS, they could not be easily separated. All letters and comments are also being posted on the State’s website. Three individual commenters were contacted regarding privacy preferences and their personal identifying information has been removed at their request prior to submission.
5. The State has scheduled a Joint Dual Demonstration Stakeholders group meeting for April 27, 2012, 1-4 PM to discuss the final design proposal, answer questions that were raised by the commenters and discuss follow up steps. All commenters were sent emails inviting them to participate in this discussion.
6. The State has reviewed all comments and has grouped them into two general categories: comments that have been already been addressed or have been added to the proposal and those that require further discussion with Stakeholders and/or internal policy makers including a number that cannot be fully addressed until more information is available from CMS.

A. Breakdown of comments:

- Two individual consumers: one for, one against.
- One RN county case manager: supportive.
- Four consumer advocacy agencies (Minnesota Board on Aging, AARP, Legal Aid and MN Consortium for Citizens with Disabilities): all supportive with extensive comments.
- Five providers/care systems (Bluestone, Essentia, Fairview Partners, Axis Health Care, Courage Center): all supportive with comments.
- Mental Health provider consortium of six agencies: supportive with comments.
- LTC Imperative: sees positive potential, but many questions and comments.
- Minnesota Council of Health Plans (MHCP) plus additional letters from five individual health plans (Blues, Health Partners, Metropolitan Health Plan, Medica, UCare): four letters of support (three included additional comments), one conditional support with additional extensive comments, one extensive comment letter looking forward to further collaboration and participation.
- Hennepin County Public Health: supportive with comments.
- Two national pharmacy organizations: comments

B. Summary of Comment Highlights by Group

1. Minnesota Council of Health Plans and five participating HMOs (Blue Plus, Health Partners, Medica, Metropolitan Health Plan and UCare).
2. General support for integration and conceptual direction, willingness to work with State and CMS, opportunity to strengthen Triple Aim goals.
3. Great concern over lack of financial information about Medicare baselines and savings projections, baselines must reflect SGR restorations and realistic costs for high needs populations, one plan wants Medicare Advantage rates for 2013 (A).
4. Long history of program makes savings less possible (A).
5. Concerns about timelines and application process, support for deeming of networks and Models of Care, one plan wants delay to 2014 for seniors, another to 2014 for disabilities.
6. Demo plans must be more involved in demo development process with State and CMS.
7. Provider contracting relationships need to be partnerships with demo plans, more information needed on ICSPs, demo plans need to be involved in development and negotiations process of ICSPs since they will be holding the risk, number of ICSPs -- too many could increase administrative costs.

8. Need much flexibility in contracting and risk/gain arrangements to accommodate current systems and attract new care systems, concern that access/networks will be reduced if new contracting arrangements are unrealistic, don't disrupt current enrollee primary care.
9. Demo plans should be involved in letters sent re: transitions of current enrollees.
10. Not enough HCH out there to accommodate population, what kind of incentives for health care homes are envisioned, will they be accommodated in rates, communications methods must consider current HIT and software capabilities .
11. Consult plans in development of outcome measures, need flexibility to have some individual performance measures, measures need to be attainable, coordinate with other measurement efforts underway, concern over duplicative CMS/State withholds , duplicative measures, role of current SNP and Stars measures.
12. Streamlining of CMS and State administrative requirements needed

C. Disability Advocates, Consumers, and Providers

1. General support for MN unique approach of state/county managed LTSS with demo plan health care services, notes need for improvements in primary and preventive care for this population, need for Medicare to be part of the picture.
2. Two consumer stories illustrate problems with disintegrated care for people with disabilities, use of 4 cards to get care, confusing notices over drug coverage, difficulty for people with mental illness to understand, wants to go back to a more seamless program as they had before SNBC and MnDHO disintegrated or ceased.
3. Wants edits to document to note state/county management of LTSS, is already managed care for which State bears risk.
4. Amend proposal to emphasize unique legislated stakeholder role in creating SNBC from the start with ongoing oversight role, leading to current shared accountability design.
5. Provides reasons CMS should consider State's model of shared accountability for LTSS (consumers do not one entity in control of all services).
6. Note history of SNPs for people with disabilities in MN, and subsequent disintegration, concerns about adequacy of Medicare payments and risk adjustment for people with disabilities.
7. ICSPs cannot use attribution model, enrollees must choose primary care or be assigned to primary care system, with options to change systems monthly (as currently allowed).
8. Model 3 should not be limited only to people with SPMI, should be available to others with diagnoses of mental illness as well.
9. Over 50% of people with disabilities have at least one mental health/cognitive condition, involve mental health providers in ICSPs.
10. Supports pursuit of Health Home options.

11. More outcomes of care related to people with disabilities, more transparency for results and measures, collection of data on health and overall wellbeing, consumers should be involved in network accessibility standards vs self report from providers, look to work done in Oregon and Massachusetts, and MAPs, for appropriate measures for Minnesota, utilize SNBC Evaluation Workgroup as forum for that discussion.
12. Appeals chart is confusing, should use different terminology for HMO internal complaint process.

D. Senior Advocates (MBA, AARP)

1. Supports align incentives between Medicare and Medicaid as logical next step in Minnesota long history of integration.
2. Do not limit choice of primary care, allow choice to change.
3. Make sure design ensures that health care is not sole driver, but is part of the team so individualized long term care services are not over-medicalized.
4. Ensure that consumers retain current protections with seamless transitions, without care disruptions.
5. Support building on HCH and state reforms. Low Medicare payments pose challenge in Minnesota.
6. Financing should be transparent to consumers.
7. Model 1 supports having consumers choose HCH/primary care clinic if enough HCH and people can change clinics.
8. Model 2 risk sharing should be designed to avoid extreme profits or losses for MMICOs or providers, more details on roles and relationships of ICSP, providers and MMICOs.
9. Ensure seamless enrollment transitions for current enrollees, more information on enrollment outreach and education and protections for passive enrollment of MSC+ enrollees, especially around Part D changes.
10. More information on stakeholder involvement in measurement development.
11. Use demo as opportunity to address home care quality, MN ranks too high (37th in nation) on preventable hospitalizations for people getting home health services.
12. Assign one care coordinator to seniors, not multiple care coordinators. [This is already the policy for seniors].
13. Pay attention to upcoming Level of Care changes, strengthen transitions requirements for people moving to lower levels of service.

E. Hennepin County Public Health

1. Supports increased collaboration between LTSS, HCH and ICSPs under non-capitated model for people with disabilities, risk and gain models under SNBC, grandfathering of SNP info for application process.

2. MOU or legislation should be clear around risk and gain , should not cost shift to county safety net.
3. Reinvest any cost savings in improvements to primary care prevention.
4. More information on roles of ICSPs and MMICOs.
5. Make marketing rules less restrictive than current rules.
6. Involve counties in outcome measures and implementation.

F. Primary Care Provider Sponsored Care Systems

1. Support for risk and total cost of care models, are currently serving MSHO members, including care coordination and some risk for long term care services, for 5-15 years.
2. Outlines savings possible using waiver of 3 day stay, in-lieu of hospital payments to SNFs, onsite orthopedic care and non-traditional substitutions of services, indicates high satisfaction of members.
3. Financing needs to consider high risk of population served.
4. Concern over aggressive implementation dates given unknowns.
5. Concern that their own payment rates have declined while health plans administrative costs are rising.
6. Concern that frequent changes in expectations and measures decrease their ability to focus on care improvements and drives up care.
7. Allow care systems to manage benefits if they are providing positive outcomes at less cost.
8. Need for data transparency including claims and assessment data to providers, quality metrics by clinic/provider county, comparisons to baselines, regular reports provided.
9. Health plans should all use common utilization measures, definitions and reporting requirements.
10. Question as to whether ACO standards can be substituted for HCH certification.
11. What happens if no HCH homes available, or if provider is not yet HCH, do people remain where they are or have to change?

G. Long Term Care Imperative (LTC Provider Consortium)

1. Views demo as positive step with potential to improve on current MSHO program as long as it improves outcomes and is more efficient but has many questions.
2. How will payments be determined, who will determine payments? How much transparency will there be in plan payments? How will savings be distributed?
3. Will people opt out or be passively enrolled?

4. How will quality be measured and rewarded, who will determine measures?
5. Notes lack of discussion in proposal of funding and incentives for LTSS. There may be enough money in the system but distribution is too siloed. Need to use SNFs and home care as alternative to hospital and assisted living as alternative to nursing home and community services in place of assisted living.
6. State should consider elimination of the 180 cap on nursing home care paid under health plans and moving to site neutral payment system.
7. LTC providers need a seat at the table in payment and funding discussions. Move to payment systems that rewards care givers and invests in adequate staffing.
8. Flexibility needed in risk and reward options for different provider abilities.
9. DHS should play a role in the ICSP contracting, ICSPs may not work in all parts of the state, should reinvest in rural areas of the State where there is the most inefficiency.
10. Concept of having Medicare savings come to state is exciting, but should be used to invest in needs such as HIT for LTC providers, and adequate staffing.
11. How will this system be different from MSHO? More clarification on roles of counties, CBPs, ICSPs and demonstration plans though recognizes that some of the ambiguity may be related to differences in ICSP models.

H. Pharmacy Providers

1. Supports person centered care for dual eligibles, past integration efforts and building on Medicare Advantage Part D plans.
2. Concern about transitions of care for MSC+ and SNBC for pharmacy benefits for enrollment, wants outline of standards for assuring continuity of care for transitions.
3. Objects to large scale of Minnesota proposal, suggests it be done in one modest area as a pilot project with evaluation instead of permanent change.
4. Expand current Medicaid MTM service to duals, MTM services should be provided by local pharmacists for duals as part of this demonstration.

II. Summary of Responses to Comments and/or Changes to Document

1. Need for flexibility in contracting and risk/gain arrangements to accommodate current care systems and attract new ones, concern that access/networks will be reduced if new contracting arrangements are unrealistic. *(Multiple models to meet varying needs are discussed in Section X and will continue to be discussed with Stakeholders.)*
2. Currently not enough HCH for all populations, will there be enough HCH, don't disrupt current enrollee primary care ,what happens if no HCH homes available, or if provider is not yet HCH, do people remain where they are or have to change? Supports having consumers choose HCH/primary care clinic if there are enough HCH and people can change clinics. *(Clarified that*

enrollees stay in current arrangements until new arrangements are available to avoid disruption in Section X.)

3. Make sure design ensures that health care is not sole driver, but is part of the team so individualized long term care services are not over-medicalized. *(Will be further addressed in development of ICSPs, clarified need for partnerships between primary care and long term care in Section X)*
4. Ensure that consumers retain current protections with seamless transitions, without care disruptions. *(BBA and Medicare Advantage protections provided under managed care regulations will continue under the demonstration, see Section XVI).*
5. Clarified that state/county management of LTSS for people with disabilities is already fully capped and managed system for which State bears risk (Section XI B).
6. Clarified unique legislated stakeholder role in creating SNBC from the start with ongoing oversight role, leading to current shared accountability design (Section XI B).
7. ICSPs should not use “attribution” model due to need for ongoing care coordination relationships, enrollees will choose primary care or be assigned to primary care system with options to change systems monthly (Clarified in Section X B.2).
8. Provide more transparency for results and measures, look at OR, MA and MAPs for appropriate measures for Minnesota, utilize SNBC Evaluation Workgroup as forum for that discussion. *(Clarified in Section XIV.)*
9. Assign one care coordinator to seniors, not multiple care coordinators. *(Clarified that this is already the policy for seniors and will continue, Section X. A.)*
10. Strengthen transitions requirements for people moving to lower levels of service due to proposed Level of Care changes. (Added to Section X.)
11. HCH communications methods must consider current HIT and software capabilities. *(Clarification in Section X B. I.)*
12. Model 3 should not be limited only to people with SPMI, should be available to others with diagnoses of mental illness as well. *(Clarified that model is not restricted to serious and persistent mental illness diagnoses, could be adapted to other disability groups with co-occurring mental illness/cognitive impairment, further discussion on this with CHM and CC is in progress, Section X B.4.)*
13. How will quality be measured and rewarded, who will determine measures? Consult current plans and providers in development of outcome measures, need flexibility to have some individual performance measures, measures need to be attainable, health plans should all use common utilization measures, definitions and reporting requirements, provide more information on stakeholder involvement in measurement development, involve counties, care systems, long term care providers, consumers, plans in outcome measures and implementation. *(Clarified further stakeholder involvement in measurement in Section XIV, including need to have more information about CMS required measures before we can finalize state measurement plans.)*
14. Concern about short CMS application timelines and continued SNP requirements, duplication of Medicare and Medicaid requirements, concern that current plans must be more involved in

discussions, questions about three-party contracting process. *(Addressed in Appendix 3 follow up discussions with plans and CMS being scheduled.)*

15. Need for data transparency including claims and assessment data to providers, quality metrics by clinic/provider county, comparisons to baselines, regular reports provided to providers. *(Clarified in XV).*
16. Reinvest any cost savings in improvements to primary care prevention. *(Section XI: the State has proposed to cover HCH payments out of Medicare savings.)*
17. Clarified that demo plans should be involved in letters sent re: transitions of current enrollees. *(Section VI)*
18. Provide outline of standards for assuring continuity of care for transitions around Part D changes. *(Clarified that we will examine current Part D continuity requirements to determine any additional needs and discuss with stakeholders, in VI.)*
19. What kind of incentives for health care homes are envisioned, will they be accommodated in rates? *(This was not meant to require payments beyond current required HCH payment but demonstration plans should also explore additional means of encouraging clinics to become certified HCHs. Changed ‘incentives’ to ‘encourage’ in X.)*
20. One plan wants Medicare Advantage rates for 2013 and delay to 2014 for implementation for Seniors. *(Implementation date is still contingent on financing model being viable for Minnesota, further discussions with plans are being scheduled.)*
21. One plan wants delay to 2014 for people with disabilities. *(Discussing timelines further with plans and CMS.)*
22. Concern that provider payment rates have declined while health plans administrative costs are rising. *(The Minnesota legislature has made a number of cuts in provider rates in recent years but has also capped administrative costs for health plans at 6.2%.)*
23. Objects to large scale of Minnesota proposal, suggests it be done in one modest geographic area as a pilot project with evaluation instead of permanent change. *(Comment is from out of state pharmacy provider group, notes change in Part D plans for people enrolled in demonstration, but MN has had statewide integrated system for seniors since 2005 and for people with disabilities since 2008, so demonstration is in fact not a large change for MN. A move to a pilot would be a step backwards for integration in MN.)*

III. Summary of Comments Requiring Further Follow Up

1. Provider contracting relationships need to be partnerships with demo plans, more information needed on ICSPs, demo plans need to be involved in development and negotiations process of ICSPs since they will be holding the risk, will there be limits on number of ICSPs-too many could increase administrative costs. *(Will continue to discuss further with demonstration plans and providers.)*

2. More clarification on payment for and roles of counties, CBPs, ICSPs and MMICO demonstration plans. *(Models are evolving, will continue to discuss with stakeholders, some clarifications added to Section X.)*
3. How will payments be determined, who will determine payments? How much transparency will there be in plan payments? How will savings be distributed? *(Need more information on financial/rates models from CMS before we can design payment models and provide answers to these questions.)*
4. State should consider elimination of the 180 cap on nursing home care paid under health plans and moving to site neutral payment system. *(Would require legislation, will discuss further with Continuing Care, Budget officials and long term care providers.)*
5. Can ACO standards can be substituted for HCH certification. *(Requires further discussion.)*
6. Demo plans must be more involved in demo development process with State and CMS. *(Will address directly with plans and CMS in upcoming calls.)*
7. Appeals chart is confusing, should not use “appeal” terminology for Medicare HMO internal complaint process. *(Removed “Grievance” in title of Appendix 2, have offered to follow up with commenter.)*
8. Use demo as opportunity to address home care quality, MN ranks too high (37th in nation) on preventable hospitalizations for people getting home health services. *(Have referred issue to Continuing Care for follow up.)*
9. Should collect more data on health and overall wellbeing of people with disabilities. *(DHS collects more data than the public is likely aware, will discuss with Stakeholders group. CMS is planning data collection so is difficult to move forward until those requirements are clarified. Will share available information on CMS evaluation with Stakeholders and discuss further in next SNBC Evaluation Workgroup scheduled for May 17.)*
10. Need to use SNFs and home care as alternative to hospital and assisted living as alternative to nursing home and community services in place of assisted living. *(Agree; will share best practices in Stakeholders meeting.)*
11. LTC providers need a seat at the table in payment and funding discussions. *(LTC providers are included in the Stakeholders groups, Section X clarified re: partnerships with LTC providers.)*
12. Move to payment systems that rewards care givers and invests in adequate staffing. *(Requires follow up discussion.)*
13. Should reinvest savings in rural areas of the State where there is the most inefficiency. *(Requires follow up discussion.)*
14. Invest in needs such as HIT for LTC providers, and adequate staffing. *(Discuss internally at DHS.)*
15. Expand current Medicaid MTM service to duals, MTM services should be provided by local pharmacists for duals as part of this demonstration. *(Part D is not changing. MTM is a Part D covered service, so would be a cost to the State to cover it under Medicaid for duals.)*
16. MOU or legislation should be clear around risk and gain, should not result in cost shift to county safety net. *(Agree, will have follow up discussion.)*

Letters of Support and/or Comments

Governor Dayton
Nancy Ekola
Anonymous Commenter
Anonymous County Nurse
Minnesota Board on Aging
Minnesota AARP
Minnesota Disability Law Center #1
Minnesota Disability Law Center #2
Consortium for Citizens with Disabilities
AXIS Healthcare
Bluestone Physician Services
Courage Center
Essentia Health #1
Essentia Health #2
Fairview Partners #1
Fairview Partners #2
Six Mental Health Provider Agencies
The Long-Term Care Imperative
Minnesota Council of Health Plans
Blue Plus
HealthPartners #1
HealthPartners #2
Metropolitan Health Plan
Medica
UCare #1
UCare #2
Hennepin County Human Services and Public Health Department
PhRMA
National Association of Chain Drug Stores

[REDACTED] (DHS)

From: Nancy Ekola <[REDACTED]>
Sent: Tuesday, March 27, 2012 1:48 PM
To: *DHS_Dual Demo
Subject: Comment on draft proposal

Hi,

Re: <http://www.dhs.state.mn.us/dualdemo>

Minnesota's Demonstration to Integrate Care for Dual Eligibles

Please integrate Medicare and Medicaid Healthcare in Minnesota.

I used to have a plan that integrated my Medicare, Medicaid and my prescription coverage. Now I have to carry 4 different insurance cards: Medica, Medicare, MA, and First Health Part D. I have a Mild Brain Injury and several health conditions that I deal with on a daily basis. This current system is quite confusing for me and my providers. It can be very difficult to set up a something like physical therapy or cancer screenings. Generally when I need something, I have to contact several people at different organizations to get it going. I am a Breast Cancer survivor, so some of my care issues are urgent.

When I had the combined plan with AXIS - Medica, my care was much better.

Thanks,
Nancy

--

Nancy Ekola
Hope Ability

[REDACTED]
[REDACTED].com

[http://\[REDACTED\]](http://[REDACTED])

From: *DHS Dual Demo
To: [REDACTED]
Subject: RE: Comment on draft proposal
Date: Tuesday, April 10, 2012 5:47:17 PM

Thank you for your comments on the Dual Demo Draft Proposal. Your comment as others will be submitted to CMS in a summary document.

We would like to invite you to our next Stakeholder Meeting to review the final proposal we submit to CMS as well as the comments we received.

The next Stakeholder Meeting is scheduled for April 27th, 2012. 1:00 pm to 4:00 pm at 540 Cedar Street ELA 2370 and 2380. We hope you are able to attend this meeting.

Please let us know if you have any additional comments or concerns.

From: [REDACTED]
Sent: Monday, April 09, 2012 12:07 PM
To: *DHS_Dual Demo
Subject: Comment on draft proposal

We oppose this proposal because it may just weaken medicare more.

[REDACTED]
[REDACTED]
[REDACTED], Mn. [REDACTED]

Caution: This e-mail and attached documents, if any, may contain information that is protected by state or federal law. E-mail containing private or protected information should not be sent over a public (nonsecure) Internet unless it is encrypted pursuant to DHS standards. This e-mail should be forwarded only on a strictly need-to-know basis. If you are not the intended recipient, please: (1) notify the sender immediately, (2) do not forward the message, (3) do not print the message and (4) erase the message from your system.

[REDACTED] (DHS)

From: [REDACTED]
Sent: Friday, April 13, 2012 12:05 PM
To: *DHS_Dual Demo
Subject: Comment on draft proposal

I am a nurse that works with BluePlus MSHO and UCare SNBC. Recently UCare stopped the integrating of Medicare and Medicaid for SNBC. Several of the clients I have on SNBC have mental illness and just don't understand what the letters mean when they receive them. They have been thrown into panic situations because they receive copies of the letters to providers saying the bill isn't covered until another payer is billed. The clients do not understand, even though they were informed that UCare was going to do this. All they think is they have to pay the bill. One client had a total melt down, thinking she was going to have to pay for her meds. She decided that she should stop her meds and threw them all away. It took several visits from an ARMHS worker, several calls from me, and a visit to her Counseling Group to repair the damage. It was so much easier when it was combined and one company handled it for the client. I am in favor of the two being combined so the client isn't caught in the middle.

[REDACTED]

[REDACTED] County

[REDACTED]

Office [REDACTED]
Fax [REDACTED]

CONFIDENTIALITY NOTICE

[REDACTED]



David Godfrey
Medicaid Director
MN Department of Human Services
PO Box 64983
St. Paul, MN 55164-0983

April 23, 2012

Dear Mr. Godfrey:

I am writing to express the support of the Minnesota Board on Aging (MBA) for the Department of Human Service's proposal for Re-designing Integrated Medicare and Medicaid Financing and Service Delivery for People with Dual Eligibility. The MBA has been actively engaged in the development of this proposal through participation in the Stakeholders' Advisory Committee and will continue to be engaged as this proposal is implemented.

In the recently-released AARP Long Term Services and Supports (LTSS) Scorecard, Minnesota was ranked first overall for state LTSS system performance. Minnesota's long history with integrated products for dually eligible individuals, dating back to 1995, has been a key factor in this strong performance.

The MBA has frequently noted that innovations in the delivery of long-term care services often result in savings not to the long-term care system but to the health care system. We have been advocating that Minnesota move in the direction of cost-sharing between the Medicare and Medicaid systems, in order to better align system incentives. The integration outlined in this proposal is the logical next step and will result in improved access to quality health care and long-term care services for the state's older adults.

We support providing more comprehensive and timely data to the health care systems to more fully support their efforts to manage and improve patient outcomes. Access to frequent and timely data that includes both Medicare and Medicaid will provide the health care systems with a nearly complete picture of their patients' health and long-term care experience.

As this proposal goes forward, we urge the state to be mindful of the following issues:

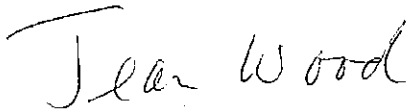
- Even with an emphasis on the use of certified health care homes to provide primary care to enrollees, the benefit design should not limit individuals' choice of primary care providers, and individuals should have the ability to easily change their primary care provider.
- Stronger integration between health care and long-term care services could lead to over-medicalization of the long-term care services, and we must take steps to guard against this. The strength of the long-term care service system is its ability to view and support the individual in a holistic manner, taking into account the person's preferences, risk

tolerance, and informal support network. The design of the integrated model must ensure that the health care system is not driving decision-making, but acts as part of a team to support the individual's decisions about care.

- As Medicare and Medicaid services and payment systems become more fully integrated, we must ensure that consumers retain the current protections available to them under both systems. For example, as current products are transitioned to Medicare Medicaid Integrated Care Organizations (MMICOs), consumers should experience a seamless transition with no disruption in their care plan, while being fully informed of the change. In general, we are interested to know more about the state's plans for enrollee education and outreach, and enrollee support prior to and during the launch of the initiative.

The MBA appreciates the opportunity to respond to and provide support for the effort to integrate health care and long-term care services and payment system. The result will be systems that are more responsive to the needs of Minnesota's growing number of dually eligible older adults, and ultimately, to the needs of all individuals with multiple chronic conditions. We look forward to our continued partnership.

Sincerely,

A handwritten signature in cursive script that reads "Jean Wood".

Jean Wood
Executive Director



April 19, 2012

Mr. David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164
Via email: dual.demo@state.mn.us

Dear Mr. Godfrey,

On behalf of our more than 650,000 members in Minnesota, AARP appreciates the opportunity to comment on Minnesota's proposal to re-design and integrate Medicare and Medicaid Financing and Delivery for People with Dual Eligibility. We appreciate the efforts of the Minnesota Department of Human Services in developing this proposal to better align our current fragmented system to improve the care for individuals who are dually eligible for Medicare and Medicaid.

In general, AARP is supportive of this proposal that builds on our existing programs including– the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs BasicCare (SNBC) – and seeks to redesign those programs to improve performance of primary care and care coordination models through new Medicare/Medicaid Integrated Care Organizations (MMICOs).

We also are pleased that the proposal builds on the many current reforms that are taking place in Minnesota. These reforms include the all-payer Health Care Home (HCH) program, the CMS Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), the Health Care Delivery System Demonstration (HCDS) projects, the Medicaid total cost of care (TCOC) payment pilot projects, and LTSS redesign efforts. We are encouraged by the Department's willingness to develop new outcome measures to adequately reflect the dual population.

To the extent that this proposal builds on the existing managed care programs and maintains many design features regarding consumer protections, benefits, eligibility, and enrollment, our comments below will focus on the key changes and additions contemplated in the proposal.

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MMICO Transparency and Accountability

We understand and appreciate the enormous challenge that Minnesota faces in developing the right financing model given that Medicare rates have been below average and our long history of integration may make it difficult to achieve savings. However, we believe it is very important to ensure that any financing and payment structures are transparent to consumers. We believe the State's response to the concerns around the profitability of HMOs was appropriate and are hopeful these measures will continue in the dual demonstration as well.

Our comments on the three new payment and delivery system model reforms in the MMICO's are as follows:

Model 1: Primary Care Health Care Homes - We support the requirement that all demonstration enrollees choose a primary clinic, preferably a certified Health Care Home, as long as we can ensure that consumers have adequate clinic choices and the ability to easily change clinics if needed.

Model 2: Integrated Care System Partnerships (ICPS) - This model proposes integrating delivery of primary, acute and long term care services to MMICO members along with risk/gain sharing arrangement options. We conceptually support this integration. However, we must ensure that the development of risk-sharing mechanisms avoids either windfall profits to health plans/provider groups or devastating losses.

Model 3: Chemical Mental and Physical Health Integration Partnerships - We believe this design plan can more effectively address the needs of people with mental illness, including those with co-occurring substance abuse. However we must ensure that the care delivery is not fragmented as people move from acute care to long-term care.

Consumer Protections

It is our understanding that most seniors currently enrolled in managed care (almost 80%) would experience a seamless transition with no care disruptions when their current plans convert to MMICOs under three-way contracts. However, those MSC+ enrollees that do not opt out (and some SNBC enrollees in the future) will be moving from Medicare fee-for-service to Medicare coverage under a managed care contract through the D-Special Needs Plans (SNP) arrangement, and care must be taken to ensure a similar experience.

The proposal calls for further protections against changes in medication access for those MSC+ or SNBC enrollees who experience a change in their Medicare Part D prescription drug coverage when they are enrolled with an MMICO. However, there are no details in

Mr. David Godfrey
April 19, 2012
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the proposal as to specific protections. AARP is interested in learning more about plans for enrollee education and outreach, and enrollee support prior to and during the launch of the initiative for enrollees who would have to change drug coverage.

Enrollment Process

It is our understanding that the proposal outlines how current managed-care enrollees will be automatically transitioned to demonstration status (i.e., MSHO and SNBC enrollees that are currently enrolled in a D-SNP). AARP is concerned that for passive enrollments, the proposal does not provide enough details about the actual enrollment process, nor how members will be informed, counseled and supported during the transition process.

The passive enrollment system should provide prospective enrollees with advance notice and a longer election period to select one of the MMICO's. In addition, the MMICO should be required to provide current and prospective enrollees with information on provider networks, as well as data on comparative quality ratings for each network's providers when such ratings are available.

Finally, AARP is interested in seeing greater detail on the respective roles of the state, MMICOs, county managed care units, SHIP programs, and other stakeholder and advocacy groups in the passive enrollment transition process.

Quality Management System

Minnesota has extensive experience in monitoring various programs for quality improvement and access. We support provisions in the proposal that call for the state to take a more active role in guiding evidence-based practices in all the contract requirements to ensure consistency and increased accountability. However, new measures and areas of focus relevant for dual eligibles have not yet been defined. While the state plans to work with CMS and has also hired a consultant to assist in this effort, AARP believes there should be a better understanding and additional detail regarding the process for selecting measures or how stakeholder involvement and input will be accomplished.

While we recognize the enormous challenge to reconcile and align all the various State, Federal and community measurement initiatives, we urge the Department to explore developing other incentive payments to address home care quality. As AARP's Long-Term Services and Supports Scorecard (attached) recently highlighted, Minnesota ranked 37th in the nation in the percent of home health residents who needed a hospital admission (the lower the ranking, the higher the number of admissions). We believe more should be done to address this lower-ranking quality indicator.

Mr. David Godfrey
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Page Four

Care Coordination

AARP recognizes that many dually-eligible individuals see multiple providers and specialists, and coordinating all of these medical and non-medical services is a monumental task for beneficiaries and their caregivers. However, we believe that we have a real opportunity in the MMICOs to further improve the care coordination for enrollees. Doing so may not only improve the quality of care, but it may also reduce costs. Too often we hear from consumers that they either have too many coordinators with no one person being ultimately responsible, or there is a lack of care coordination between the acute and long-term care systems.

AARP urges the state to establish one care coordinator for each enrollee in the new MMICOs to have primary responsibility for the management of all care needs for each enrollee.

Eligibility for Long-Term Services and Supports

While the proposal does not specifically address the eligibility or level of care determination process, given the potential for disruption of care for seniors who would fail to meet the revised Nursing Facility Level of Care (NF-LOC) criteria upon federal approval, we believe this proposal should address the continuity of care as individuals transition to other, less robust and possibly inadequate programs.

Conclusion

AARP appreciates your efforts to continue building on Minnesota's extensive experience operating managed care programs for seniors, and we thank you for the opportunity to offer the above recommendations that can improve the proposal further. We believe this is a good start and stand ready to work with you as this important initiative is implemented.

If you have any questions or would like additional information, please do not hesitate to contact Mary Jo George, AARP Minnesota Associate State Director for Health and Long Term Care, at mjgeorge@aarp.org.

Thank you again for your consideration.

Sincerely,



Michele H. Kimball
Director, AARP Minnesota



Minnesota: 2011 State Long-Term Services and Supports Scorecard Results

Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the first of its kind: a multi-dimensional approach to measure state-level performance of LTSS systems that provide assistance to older people, adults with disabilities, and family caregivers. The full report is available at www.longtermscorecard.org

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Minnesota ranked:

Overall 1

- Affordability and access 4
- Choice of setting and provider 3
- Quality of life and quality of care 4
- Support for family caregivers 4

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Minnesota improved its performance to the level of the highest-performing state:

- 7,895 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 4,249 nursing home residents with low care needs would instead be able to receive LTSS in the community.

MINNESOTA

State Long-Term Services and Supports Scorecard Results

2011 Scorecard

OVERALL RANK	1				
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	219%	21	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	110%	48	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	71	9	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2008-09)	53.9%	12	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2007)	74.6	1	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale 0-12) (2010)	11.0	1	7.7	10.5	11.0
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)	60.0%	3	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	83.3%	1	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	12.2	20	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	2.90	16	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age 65+ (2009)	108	1	34	88	108
Assisted living and residential care units per 1,000 population age 65+ (2010)	80	1	29	64	80
Percent of nursing home residents with low care needs (2007)	14.5%	32	11.9%	5.4%	1.3%
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	73.9%	5	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	86.3%	18	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability age 18-64 (2008-09)	36.0%	5	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores (2008)	6.6%	1	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	1.9%	11	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	36.8%	12	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	8.3%	1	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	88%	35	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	31.3%	37	29.0%	23.2%	21.8%
Percent of caregivers usually or always getting needed support (2009)	81.7%	3	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-09)	3.70	17	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	13	13	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

Refer to Appendix B2 in *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for indicator descriptions, data sources, and other notes about methodology. The full report is available at www.longtermscorecard.org



MINNESOTA DISABILITY LAW CENTER
Duluth Fertile Grand Rapids Mankato Minneapolis
Anne L. Henry ▪ (612) 746-3754 ▪ alhenry@midmnlegal.org

April 19, 2012

David Godfrey
State Medicaid Director
Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

RE: Letter of Support for Minnesota's Proposal for Integrated Medicare and Medicaid Financing and Delivery for Persons with Disabilities

Dear Mr. Godfrey:

We are writing to support Minnesota's proposal to integrate Medicare and Medicaid financing and service delivery for persons with disabilities. We are supportive of Minnesota's unique model of integrated care for persons with disabilities which combines medical services contracted through Minnesota's nonprofit health maintenance organizations and long-term services and supports managed by the state through Minnesota's counties and tribes.

While Minnesota's structure of managing medical services and long-term services is unique, we believe Minnesota's structure fulfills the major requirements of integration: limiting opportunities for cost shifting and providing strong incentives for care coordination.

Because our state Department of Human Services contracts for health care services with health plans and also manages the long-term services and supports system, the state bares the risk of failure to provide needed services for both the acute care and long-term care services needed by many persons with disabilities eligible for Medicaid and Medicare in our state.

We believe that other states will benefit from Minnesota's pursuit of this model of integration. As advocates for persons with disabilities in our state, we have worked with other disability organizations, our state legislature and Department of Human Services staff to structure

The Protection and Advocacy System for Minnesota

430 First Avenue North, Suite 300 Minneapolis, MN 55401-1780

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David Godfrey
April 19, 2012
Page 2

management of long-term services and supports outside of the typical health plan contract. It is extremely important to persons with disabilities to obtain employment, housing, transportation and full participation in their communities. Health plans provide health care and do not have experience or expertise in these many areas of supports needed for a fully integrated life in the community. Handing over control of most aspects of a person's life to one entity is not consistent with the self-directed service model which is so important to persons with disabilities. Therefore, we urge that CMS acknowledge Minnesota's unique model of integration for persons with disabilities who are eligible for both Medicare and Medicaid and allow our state to participate in the financing and service delivery demonstration.

Sincerely,

Anne L. Henry
Attorney at Law

ALH:mnu/nb

1110-0325725--938460



MINNESOTA DISABILITY LAW CENTER
Duluth Fertile Grand Rapids Mankato Minneapolis
Anne L. Henry ▪ (612) 746-3754 ▪ alhenry@midmnlegal.org

TO: Deb Maruska and Other Staff
FROM: Anne L. Henry
RE: Comments on “Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota”
DATE: April 19, 2012

The following are comments on the draft CMS Design Proposal dated March 22, 2012, submitted on behalf of the persons with disabilities we represent at the Minnesota Disability Law Center.

1. **Minnesota’s Unique Structure Qualifies for the Demonstration and Meets the Requirement to Provide Integrated Health Care and Long-Term Support for Persons with Disabilities**

While Minnesota has a unique structure in terms of the CMS parameters for the Medicare/Medicaid Integrated Demonstration, we think the description of Minnesota’s structure for persons with disabilities age 18-65 could be improved by a stronger emphasis on the following two aspects:

- a. the fact that long-term services and supports (LTSS) system is managed by the state Medicaid agency and essentially capitated, as described at the top of page 17 should be moved up to the initial description on page 16. Describing Minnesota’s long-term services and supports as “fee for service” is misleading and inaccurate. People are restricted from accessing providers, types of services and amounts of LTSS because they are must go through assessors or case managers to obtain service authorizations. A person cannot seek LTSS services, and pick and choose and use duplicative providers at will. Very few aspects associated with a fee-for-service system apply to Minnesota’s long-term services and supports system. The proposal will be strengthen by leading with the description of long-term services and supports as managed by the state with financial oversight on county aggregate spending, individual budgets and service authorizations for PCA, PDN, HCBS waivers, ICF//DD facilities.

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- b. SNBC does not include LTSS because persons with disabilities advocated for a model that didn't give total control over most aspects of their lives to a health plan. The medical model of providing supports is not favored by persons with disabilities and is contrary to self-directed services. Health plans do have experience in clinical health care services, but do not have expertise in employment supports, housing options, transportation, supporting relationships and community participation.

Minnesota, which has a unique SNBC structure of benefit coverage, should qualify to participate in the demonstration because the state Medicaid agency holds the contracts for health care services with licensed health maintenance organizations to provide the SNBC benefit set. The state Medicaid agency is also ultimately responsible for managing and controlling the spending on the long-term services and supports provided to SNBC enrollees. This is an accountable structure which prevents cost-shifting, since DHS is responsible for both health care and LTSS costs and, thus provides strong incentives for integration and coordination. Adding Medicare to this unique managed system would provide the opportunity to integrate all health and LTSS for those with dual eligibility.

2. **Persons with Disabilities Eligible for Medicare and Medicaid Services would Benefit from Better Coordinated and Integrated Health Care Services**

We support our state's effort to implement a demonstration project because we think there will be benefits from better integrated health care for our clients. One area of particular interest is the connection between health care home providers and residential facilities. Informed and available medical consultation for residential programs is needed and will improve the health of enrollees and reduce unnecessary hospitalizations. Because of the emphasis on integration and coordination, we think that this demonstration also offers our state the opportunity to improve prevention of secondary conditions for those with disabilities, which is a serious problem that needs attention from the health and LTSS service providers for each enrollee.

3. **Comments on Model 3, Page 14, SNBC Chemical, Mental and Physical Health Integration Partnerships**

We are in strong support of providing comprehensive health care for persons who have multiple significant diagnoses. While we certainly support serving those with a primary diagnosis of mental illness, we think limiting Model 3 to that group is unwise and unwarranted. We have found a very high proportion of people with physical disabilities, brain injuries, autism, and developmental disabilities with the most challenging health and long-term support needs to have a high rate of mental health diagnoses. Often the mental health diagnosis is not considered primary, but in fact is the underlying cause of poor physical health or high-staff intensity needs in residential settings. We urge that this model be broadened to include persons who may not have a primary diagnosis of mental illness but whose mental illness is the primary factor in their health problems or intense long-term support needs.

We are also in support of establishing a Medicaid Health Home benefit and urge that any such effort be broadened as described above so that providers who serve people with brain injury, autism, physical disabilities or other developmental disabilities who have developed expertise in treating mental health conditions for individuals with these other diagnoses are included in any proposals to provide Medicaid Health Home benefits. Consider the rate of mental health diagnoses in the Minnesota Disability Health Option population which required a physical disability for enrollment: over 80 percent of nearly 2,000 enrollees. Recent data provided by Community Support Services (state-operated nonresidential crisis services) staff revealed that of over 250 people with developmental disabilities served, about 75 percent had mental health diagnoses as well. Third, in a recent presentation on a small Pennsylvania managed care program for 100 adults with autism who require no more than 16 hours of service per day, the director stated that the biggest surprise after 4 years of managing the health and community support services was the extent of the need for clinical mental health services which involved about 65 percent of their enrollees with autism.

4. **Require Greater Accountability for Outcomes and Results from SNBC Managed Care Health Plans**

In order to really evaluate whether Minnesota is headed in the right direction to improve health and long-term supports and ultimately the overall functioning of persons with disabilities, we need to have more transparency and data on outcomes and results from SNBC health plans and LTSS services. While our state has an accessibility review for health plans to use with providers, it is a self-report. We think that our state should engage members to review clinics and report on their experience with accessibility and patient safety equipment. Also, we urge that the required quality assessment measures and performance improvement evaluation be developed with the stakeholders group so as to be more relevant and specific for persons with disabilities than we have seen to date in the managed care contracts and topic selection for persons with disabilities.

We also recommend that significant improvement in health plan contracts should be undertaken as part of this demonstration by requiring data on measures related to the well-being and functioning of persons with disabilities. Persons between age 18 and 65 with disabilities should have the opportunity for a full adult life. Their health and functioning will affect their housing, employment, income, relationships, transportation options, and participation in their communities. Serious effort is needed in our state to develop and require measures relevant to the lives of persons with disabilities.

5. **Concern about appeal terminology and resulting confusion and delay**

We urge that this new demonstration be used as an opportunity to improve the terminology and enrollee information on seeking review of health plan decisions to deny, reduce, terminate or suspend health services. The internal review of a complaint (sometimes called a grievance) required by state law for an HMO (MN Stat 62D.11) should not be part of an integrated appeal process as the chart labeled Appendix 2 states. The term "appeal" should be reserved for the Medicare or Medicaid appeal process and

Deb Maruska and Other Staff

April 19, 2012

Page 4

rights. All steps necessary to clarify terminology and enrollee information on appeal should be undertaken by DHS.

In sum, we are in strong support of our state's effort to establish a demonstration program to integrate Medicare and Medicaid financing and service delivery for persons with disabilities under age 65 who are dual eligibles. We look forward to continuing work on the specific aspects of the proposal for persons with disabilities.

Thank you for the opportunity to comment on Minnesota's draft CMS design proposal.

ALH:nb



April 19th, 2012

To: Deb Maruska, David Godfrey, other staff involved in DHS Proposal for Medicare/Medicaid Integration

From: The MN Consortium for Citizens with Disabilities (MN-CCD)

Re: Comments on DHS's draft proposal for re-designing integrated Medicare and Medicaid financing and delivery for people with dual eligibility.

The MN-CCD is in strong support of our state's efforts to establish a demonstration program to integrate Medicare and Medicaid financing and service delivery for persons with disabilities under age 65 who are dually eligible. Below you will find our specific comments.

1. Minnesota's unique structure qualifies for the demonstration and meets the requirement to provide integrated health care and long-term supports for persons with disabilities

While Minnesota has a unique structure in terms of the CMS parameters for the Medicare/Medicaid Integrated Demonstration, we think the description of Minnesota's structure for persons with disabilities age 18-65 could be improved by a stronger emphasis on the following two aspects:

- a. the fact that long-term services and supports (LTSS) system is managed by the state Medicaid agency and essentially capitated, as described at the top of page 17 should be moved up to the initial description on page 16. Describing Minnesota's long-term services and supports as "fee for service" is misleading and inaccurate. People are restricted from accessing providers, types of services and amounts of LTSS because they are must go through assessors or case managers to obtain service authorizations. A person cannot seek LTSS services, and pick and choose and use duplicative providers at will. Very few aspects associated with a fee-for-service system apply to Minnesota's long-term services and supports system. The proposal will be strengthened by leading with the description of long-term services and supports as managed by the state with financial oversight on county aggregate spending, individual budgets and service authorizations for PCA, PDN, HCBS waivers, ICF//DD facilities.
- b. SNBC does not include LTSS because persons with disabilities advocated for a model that didn't give total control over most aspects of their lives to a health plan. The medical model of providing supports is not favored by persons with disabilities and is contrary to self-directed services. Health plans do have experience in clinical health care services, but do not have expertise in employment supports, housing options, transportation, supporting relationships and community participation.

2. Improved access to primary care

We strongly support an increased focus on primary care for the non-elderly disabled population. Many duals, particularly those with multiple chronic conditions, do not have a usual source of care. Instead,

they manage their health on an emergent basis, and largely in a specialty clinic rather than a primary care context. We support requiring a primary care clinic – ideally a certified health care home – for all duals. However, current financial incentives and care coordination payments that exist today present significant barriers to entry for providers willing to serve the complex duals population. Integrating HCH payments into Medicare as an allowable cost is strongly encouraged, as the state currently accrues no savings for reductions in care costs attributable to the HCH.

3. Continued efforts to improve Medicare risk adjustment

As acknowledged in the proposal, the current SNBC plans are experiencing issues with the Medicare component. When the Medicare special needs plans began in Minnesota, all seven were fully integrated. Since then, two have exited the market entirely, and only three of the remaining five include Medicare. This leads to increased confusion and fragmentation of care experienced by enrollees. It also significantly limits the ability of the health plans to provide additional services outside the traditional Medicaid state plan benefit set. While existing SNBC plans do offer some care coordination and limited ‘extras’ such as fitness services, the absence of a stable Medicare payment platform, combined with Minnesota’s historically low Medicare rates (independent of risk adjustment due to geographic payment disparities that continue to reward high-cost, often low-value care in other states) continues to challenge the viability of these products in Minnesota. Bringing Medicare into the fold as a contracting partner with the state and the managed care plan is a positive and necessary step forward. But until CMS addresses the failures of its Medicare risk adjustment methodology, particularly as it relates to the non-elderly disabled population, we’ll be restricted to gain sharing arrangements that produce diminishing savings over time. This falls far short of current trends in the Minnesota health purchasing market, which sees gain sharing as a temporary bridge to total costs of care (TCOC) financing.

4. Persons with disabilities eligible for Medicare and Medicaid Services would benefit from better coordinated and integrated health care services

We support our state’s effort to implement a demonstration project because we think there will be benefits from better integrated health care for our clients. One area of particular interest is the connection between health care home providers and residential facilities. Informed and available medical consultation for residential programs is needed and will improve the health of enrollees and reduce unnecessary hospitalizations. Because of the emphasis on integration and coordination, we think that this demonstration also offers our state the opportunity to improve prevention of secondary conditions for those with disabilities, which is a serious problem that needs attention from the health and LTSS service providers for each enrollee.

5. Model 3, page 14, SNBC Chemical, Mental and Physical Health Integration Partnerships

We are in strong support of providing comprehensive health care for persons who have multiple significant diagnoses. While we certainly support serving those with a primary diagnosis of mental illness, we think limiting Model 3 to that group is unwise and unwarranted. We have found a very high proportion of people with physical disabilities, brain injuries, autism, and developmental disabilities with the most challenging health and long-term support needs to have a high rate of mental health diagnoses. Often the mental health diagnosis is not considered primary, but in fact is the underlying cause of poor physical health or high-staff intensity needs in residential settings. We urge that this model be broadened to include persons who may not have a primary diagnosis of mental illness but whose mental illness is the primary factor in their health problems or intense long-term support needs.

We are also in support of establishing a Medicaid Health Home benefit and urge that any such effort be broadened as described above so that providers who serve people with brain injury, autism, physical disabilities or other developmental disabilities who have developed expertise in treating mental health

conditions for individuals with these other diagnoses are included in any proposals to provide Medicaid Health Home benefits. Consider the rate of mental health diagnoses in the Minnesota Disability Health Option population which required a physical disability for enrollment: over 80 percent of nearly 2,000 enrollees. Recent data provided by Community Support Services (state-operated nonresidential crisis services) staff revealed that of over 250 people with developmental disabilities served, about 75 percent had mental health diagnoses as well. Third, in a recent presentation on a small Pennsylvania managed care program for 100 adults with autism who require no more than 16 hours of service per day, the director stated that the biggest surprise after 4 years of managing the health and community support services was the extent of the need for clinical mental health services which involved about 65 percent of their enrollees with autism.

6. Require greater accountability for outcomes and results from SNBC Managed Care Health Plans

In order to truly evaluate whether Minnesota is headed in the right direction to improve health and long-term supports and ultimately the overall functioning of persons with disabilities, we need to have more transparency and data on outcomes and results from SNBC health plans and LTSS services. While our state has an accessibility review for health plans to use with providers, it is a self-report. We think that our state should engage members to review clinics and report on their experience with accessibility and patient safety equipment. Also, we urge that the required quality assessment measures and performance improvement evaluation be developed with the stakeholders group so as to be more relevant and specific for persons with disabilities than we have seen to date in the managed care contracts and topic selection for persons with disabilities. We also recommend that significant improvement in health plan contracts should be undertaken as part of this demonstration by requiring data on measures related to the well-being and functioning of persons with disabilities. Persons between age 18 and 65 with disabilities should have the opportunity for a full adult life. Their health and functioning will affect their housing, employment, income, relationships, transportation options, and participation in their communities. Serious effort is needed in our state to develop and require measures relevant to the lives of persons with disabilities.

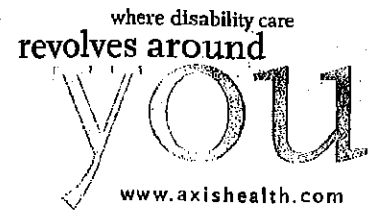
7. Appeal terminology and resulting confusion and delay

We urge that this new demonstration be used as an opportunity to improve the terminology and enrollee information on seeking review of health plan decisions to deny, reduce, terminate or suspend health services. The internal review of a complaint (sometimes called a grievance) required by state law for an HMO (MN Stat 62D.11) should not be part of an integrated appeal process as the chart labeled Appendix 2 states. The term "appeal" should be reserved for the Medicare or Medicaid appeal process and rights. All steps necessary to clarify terminology and enrollee information on appeal should be undertaken by DHS.

Thank you for the opportunity to submit comments,

Anni Simons

Anni Simons
Senior Policy and Program Manager
The MN Consortium for Citizens with Disabilities
800 Transfer Road, Suite 7A
St. Paul, MN, 55114
Office: 651 523 0823, ext 112
Email: asimons@arcmn.org



March 20, 2012

Pamela J. Parker
Purchasing and Delivery Systems
PO Box 64984
St. Paul, MN 55164

Re: Letter of Support, Dual Demonstration Project

Dear Ms. Parker:

I am writing to support Minnesota Department of Human Services efforts to obtain funding from CMS to develop the dual Medicare/Medicaid demonstration project. As an agency that provides care coordination and case management for persons with disabilities, over half of our enrollees are dually eligible.

Integrating Medicaid and Medicare contracts and payments makes sense. Not only will it reduce inefficiencies and duplication for the dually eligible, but it will streamline the process for persons with disabilities and provide for better coordinated care.

AXIS Healthcare has provided health care coordination and case management under the Medicaid waivers for over ten years. We were able to provide an integrated experience for our members through the Minnesota Disabilities Healthcare Options (MnDHO) program through healthcare coordination of Medicare and Medicaid services, and Medicaid waiver case management in one program. Unfortunately the program discontinued in 2010 due to inadequate Medicare funding. While the proposed dual demonstration project will not exactly replicate the MnDHO program, we believe it aligns with some of the positive features of MnDHO and that we have learned from our experience.

AXIS stands ready to work in partnership with DHS and other providers and advocates to assure the program's success. We look forward to our continued collaboration, and wish you the best in pursuing this worthwhile endeavor.

Sincerely,

A handwritten signature in cursive script that reads "Randall W. Bachman".

Randall W. Bachman, M.Ed., L.P.
Executive Director



March 22, 2012

State of Minnesota
Department of Human Services
Attention: Mr. David Godfrey
State Medicaid Director
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55101

Dear Mr. Godfrey:

This letter is to offer support for the redesign of existing dual eligible programs in Minnesota. Bluestone Physician Services is a Minnesota based physician group serving residents of Assisted Living and Group Homes. We serve nearly 3,000 patients with an average age of eighty-seven years. As a certified Health Care Home and a provider of care coordination services to the current MSHO, MSC+, and SNBC programs in Minnesota, we have watched the "State Demonstration of Integrate Care for Dual Eligible Individuals" initiative with great interest.

The proposal outline put forward by the State of Minnesota offers enhanced integration on several fronts including financing, quality measures, and incentives. The primary care community supports this integration and, in addition, we are in support of initiatives that work across payers and populations. In particular, we believe it is important to have Medicare financing integrated for the frail elderly and disabled populations which Bluestone serves.

Health Care Home clinics that serve a high percentage of dual eligible beneficiaries routinely deal with multiple, if not conflicting, messages regarding billing, reporting, and outcome measures. The proposal's recognition of the importance of including Health Care Home clinics in all of the models is encouraging. This approach will lead to greater efficiency for clinics and less confusion for beneficiaries.

We believe that, overall, the primary care community in Minnesota is receptive to primary care payment reform including risk based models and total cost of care. On behalf of Bluestone, I welcome the opportunity to further engage in innovative models that meet the needs of this vulnerable population.

Sincerely,

Dr. Todd Stivland

270 Main Street North, Stillwater, MN 55082
651-342-1039 (p) 651-342-1428 (f)
www.bluestonemd.com



David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164-0983

April 18, 2012

RE: Minnesota's Demonstration To Integrate Care For Dual Eligibles

Thank you for the opportunity to respond. Courage Center strongly supports Minnesota's continued efforts to improve care integration for the most challenging segment of the Medicaid population – dual eligibles. While Minnesota is aggressively moving forward with health delivery and financing initiatives in a number of areas, addressing the needs of the primary cost drivers in our Medicaid program is very welcome.

1. Improved access to primary care

We strongly support an increased focus on primary care for all dual eligibles, but particularly for the non-elderly disabled population. Many duals, particularly those with multiple chronic conditions, do not have a usual source of care. Instead, they manage their health on an emergent basis, and largely in a specialty clinic rather than a primary care context. We support requiring (or even assigning) a primary care clinic – ideally a certified health care home – for all duals. We recognize that the number of disability-competent primary care providers is in short supply, and that current financial incentives and care coordination payments are insufficient to entice providers (or large provider systems) to serve the complex duals population differently than they do today. Integrating Health Care Home (HCH) payments into Medicare as an allowable cost is strongly encouraged, as the state currently accrues no savings for reductions in care costs attributable to the HCH.

The question of prospectively assigning or retrospectively attributing members to particular providers or care systems is unaddressed in the proposal. In our experience, attribution is problematic for this highly complex population that often has multiple comorbidities. The Courage Center HCH has a high percentage of duals (38 percent) with an average on nine chronic conditions. For reasons outlined above, they often present at multiple specialty clinics and or hospitals for emergent issues. Utilization patterns may suggest attribution to a provider other than Courage Center who treated an exacerbation or pressing condition, but that provider may not be willing or qualified to accept the responsibility that a HCH for complex/chronic disability requires. While both CMS, through its ACO regulations, and DHS through the HCDS provider-based reform opportunities as well as the SNBC plans, have fostered a consumer choice, or opt out, approach. We strongly favor this assignment approach, (as opposed to retrospective

attribution) with an allowance for a transition to another primary care provider if the assigned and initial provider is unsatisfactory to the enrollee.

2. Continued efforts to improve Medicare risk adjustment

A great deal was learned from the now defunct Minnesota Disability Health Options (MnDHO) program. This capitated, fully integrated Medicare-Medicaid managed care experiment served a highly complex population of 1200 non-elderly individuals with physical disabilities. Monthly capitation rates ran as high as \$7700 for some enrollees, a majority of whom had co-occurring mental health and chronic pain issues. Half of the MnDHO enrollees were duals. Consumer satisfaction with MnDHO was very high and the flexible benefits approach, coupled with intensive care coordination, was successful in transitioning hundreds of individuals from institutional settings to the community. However, after 10 years of operation, MnDHO collapsed under the weight of an inadequate financing methodology, largely due to the failures of Medicare risk adjustment. Removal of the frailty factor for this program's target population was highly problematic. Please take this opportunity to a) remind CMS of the state's broad and deep experience in fully integrating care for those who are expensive statistical outliers (both MSHO and MnDHO) and b) that the failure of the Medicare risk adjustment methodology and payment directly led to the discontinuation of this program.

Unfortunately, the same risk adjustment phenomenon is happening to the current SNBC plans, as acknowledged on p.8 of the proposal. When the Medicare special needs plans began in Minnesota, all seven were fully integrated. Since then, some have exited the market entirely, and only three of the remaining five include Medicare. This leads to increased confusion and fragmentation of care experienced by enrollees. It also significantly limits the ability of the health plans to provide additional services outside the traditional Medicaid state plan benefit set. While existing SNBC plans do offer some care coordination and limited (and welcomed) 'extras' such as fitness services, the absence of a stable Medicare payment platform, combined with Minnesota's historically low Medicare rates (independent of risk adjustment due to geographic-based benchmark payment disparities that continue to reward high-cost, often low-value care in other states) continues to challenge the viability of these remaining products in Minnesota. Bringing Medicare into the fold as a contracting partner with the state and the managed care plan is a positive and necessary step forward. But until CMS addresses the failures of its Medicare risk adjustment methodology, particularly as it relates to the non-elderly disabled population, we'll be restricted to gain sharing arrangements that produce diminishing savings over time. This falls far short of current trends elsewhere in the Minnesota health purchasing market, which sees gain sharing as a temporary bridge to total cost of care (TCOC) financing.

3. Leveraging virtual integration with shared accountability present in the current system to share in Medicare savings

Minnesota's existing – and intentional – managed health care system for the non-elderly disabled, created in partnership with multiple stakeholder groups, should be stressed

more strongly. I'm unaware of any other state with statutory requirements for public discourse hosted by the Medicaid agency in advance of significant changes to publicly funded managed care programs. This is a model for transparency and it was in this context we carefully crafted the "virtual integration" of SNBC plans coupled with "shared accountability" for long-term care services and supports referenced on p.16. We strongly believe this aligns with the intent of (and is consistent with) the July 8, 2011, CMS letter to state Medicaid directors, "Re: Financial Models to Support State Efforts to Integrate Care for Medicare/Medicaid Enrollees".

Minnesota is not unique in this regard with its proposal for virtual integration. Oregon is pursuing a similar approach with its creation of Coordinated Care Organizations (CCOs). These entities will receive a single payment for managing the physical, behavioral and oral health care of enrollees for purposes of the demonstration, but LTSS services are excluded from these global budgets. CCOs will "share accountability with the (LTC) system for ensuring the care delivered to individuals receiving long terms care services is coordinated and aligned."

Meticulous care was taken through countless hours of multi-stakeholder work sessions to define both benefit parameters for SNBC Medicare Advantage plans as well as consumer protections. Expectations exist that health plans will coordinate with counties or their contracted partners in the development of care plans (as needed) and coordinate the services needed across the continuum of care—including LTSS that may be reimbursed in a fee-for-service (FFS) context. To be clear, these LTSS services are tightly managed by counties, and they are at risk, in the aggregate, for the delivery of these LTSS services for their Medicaid population within a fixed budget allocation. It should also be noted that the contracted care coordinators selected by the health plans to manage the SNBC services are often the same people charged with managing the LTSS services in a FFS context, particularly in rural counties. This is a much more positive experience for the SNBC enrollee who may also have Medicaid waiver benefits, who then has one individual to manage their medical and social needs and supports.

In short, Minnesota should be allowed to share in Medicare savings for its historic, planful, transparent, and accountable approach to crafting delivery and financing systems for dual eligibles under age 65. These were created with strong consumer protections in mind by all interested stakeholders in partnership with DHS. Medicare savings for the majority of enrollees now in SNBC plans with no Medicare participation have to date accrued to the federal government.

4. Improved accountability to increase CMS confidence in Minnesota's approach to integration

As mentioned above, significant stakeholder involvement was critical in building SNBC contracts with health plans that reflected multiple domains of consumer protection, especially access to needed services. The outcome targets mentioned on p.17 (addressing transitions and utilization) are a great start. To date many of the performance

improvement plans (PIPs) targeted by DHS for its annual contract withholds are helpful but insufficient. While these chosen benchmarks (diabetes protocols, access to primary or dental care) are important, they don't necessarily capture the complexity of the population or more importantly, the patient experience. I would strongly suggest DHS review the recent report released by the Measure Applications Partnership (MAP), a multi-stakeholder partnership of 60 private-sector organizations convened by the National Quality Forum (NQF). MAP was charged by the U.S. Department of Health and Human Services (HHS) with developing a quality measurement strategy for care provided to dual eligible beneficiaries. The report, "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population," is widely available online.

Other states are offering exciting and robust evaluation approaches. Oregon has developed both core measures and transformational measures of success, with the former including things like patient experience, ED visits and avoidable hospital admissions, while the latter includes improved mental or physical health and timely delivery of medical records following a transition of care. Massachusetts is examining multiple domains including person-centered care, integration of care, and cost savings, with a particular focus on integrating mental health services, which is critical for this population. DHS has an existing evaluation workgroup where this important work can be done with stakeholder input, as has been our strong tradition. While we must account for differences in the acuity of enrollee populations across plans and care systems, we should not let this stop us from developing a comprehensive evaluation system that clearly demonstrates where value is added in both care processes and client outcomes. The greater our willingness to prove the effectiveness of our approach to care delivery, the greater the confidence CMS will have in our approach.

Again, Courage Center is appreciative for the opportunity to respond to and strongly support Minnesota's effort to better integrate care for its dually eligible enrollees of all ages. We look forward to working with you as these initiatives move forward.

Sincerely,



John Tschida
Vice President, Public Affairs & Research
Courage Center
763-520-0533



Essentia Health

Here with you

24 April 2012

David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164-0983

RE: Letter of Support for *Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota* proposal

Dear Mr. Godfrey:

Essentia Health submits this letter of support for the Minnesota Department of Human Services (DHS) proposal for *Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota*.

Essentia Health is an integrated health system serving patients in Minnesota, North Dakota, Wisconsin and Idaho. We are committed to helping patients and their families lead active and fulfilling lives. A key part of this commitment is care coordination for frail elders, especially persons eligible for both Medicare and Medicaid. We have worked with DHS and the Minnesota Senior Health Options (MSHO) program since 2005, offering care coordination services to elders in northeastern and northwestern Minnesota. Integrated services through MSHO help to improve the health of frail elders and allow them to remain living independently in the community. The proposed program redesign is an opportunity to continue to improve care for elders in Minnesota.

Once again, thank you for the opportunity to submit a letter of support for the state's proposal. We look forward to continuing our collaborative efforts with DHS to improve the care of elders in our state.

Sincerely,


John Smylie
Chief Operating Officer



Essentia Health

Here with you

6 April 2012

Deborah Maruska
DHS – Purchasing and Service Delivery
PO Box 64984
St. Paul, MN 55164-0984

RE: Comments regarding draft proposal for *Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota*

Dear Ms. Maruska:

Essentia Health has reviewed the state's draft proposal for *Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota*. We have worked with the Minnesota Senior Health Options (MSHO) program since 2005 and remain interested in working with DHS to improve care for persons eligible for both Medicare and Medicaid.

We submit the following comments to the published draft proposal:

- *“Primary care providers that are not already certified as HCH under these current care systems would be required to participate as HCH and would be provided a transition period in order to accomplish this prior to any contract requirements.” (pg. 14).*
Would participation in other health care home-like projects exempt a care system from the HCH certification? For example, Essentia Health intends to participate in the MN Medicaid ACO project, which has similarities to HCH certification. In addition, the details surrounding the transition period (e.g., length of time, details required) are lacking and we suggest the state further describe what the requirements may entail.
- *“Since it will take more time to design RFPs and negotiate these new partnerships and to offer enrollees choice of arrangements, Models 2 and 3 below would be implemented during 2013.” (pg. 14).*
It is unclear how existing member relationships will be preserved during the RFP period. Would existing MSHO members transition to a Model 1 provider in January until the RFP is issued and providers selected? Alternatives could include:
 - Moving up the RFP development, release, and selection, to coincide with the rollout of the demonstration product.
 - Allowing current care system partners a transitional period in which to continue serving existing members while responding to the RFP.

- *“The State is in the process of engaging a contractor to assist in identifying which measures are most appropriate for dually eligible demonstration participants.” (pg. 19).*
We support the State’s desire to identify appropriate measures and outcomes. We suggest adding language to add relevant stakeholders, including providers, in the identification of appropriate measures. We also support utilizing existing measurement processes and data collection sources, rather than developing additional ones.

- *“MMICOs/ICSPs will be encouraged through the RFP process and contract requirements to utilize evidenced practices and guidelines to achieve specified improvements in outcomes for enrollees.” (pg. 15).*
We support the use of evidence-based practices and suggest that provider input be included in the development of guidelines, benefit design, and utilization review, to add discipline into the process of care.

- *“The State will utilize a multi-level approach to data analysis...” (pg. 20).*
We support the State’s desire to utilize data in further development of the demonstration. We suggest additional and stronger transparency, including:
 - Making raw data available to partners, including claims, assessment information, and MDS information.
 - Providing quality metric information in ways that can be analyzed (e.g., by clinic, by county of residence, by MMICO/ICSP, by model, compared to baseline, etc.).
 - Providing reports on a regular interval (e.g., quarterly).
 - All health plans to follow and report on common utilization/quality measures in ways that allow for easy comparison (e.g., standard measure definitions, common reporting periods, standard reports, etc.).

Once again, thank you for the opportunity to comment on the draft proposal. If you have questions or would like further information/clarification, please do not hesitate to contact me.

Sincerely,

Joseph Grant
Clinic Manager – Elder Care/MSHO
Joseph.Grant@EssentiaHealth.org
(218) 786-8248

April 19, 2012

David Godfrey
Minnesota Medicaid Director
P.O. Box 64983
St. Paul, MN 55164-0983

Fairview Partners

3400 West 66th Street
Suite 290
Edina, MN 55435
Tel 952-914-1720
Fax 952-914-1727

Dear David:

Fairview Partners strongly supports the proposal from the State of Minnesota to redesign existing managed care programs for dual eligibles. As a participant in the Minnesota Senior Health Options (MSHO) product for 15 years, we have found that the integration of benefits/services and financing allows for greater flexibility in care plan design.

Fairview Partners is an integrated health care system model utilizing care coordination for care delivery across the continuum. We provide person-centered, individualized care plans for the senior dual eligible population. The flexibility of the MSHO program allows dual eligible seniors to receive individualized, person-focused care.

Due to the MSHO program, Fairview Partners has been able to make health care interventions that are cost-effective, increase member satisfaction (see attached grid) and produce positive health outcomes. Some examples include:

- Waiving the three-day qualifying hospital stay and directly admitting MSHO members into transitional care units (TCUs):

Cost Savings

Total savings by direct TCU admit per episode = \$7,500 (the approximate cost of a hospitalization/ER/ambulance)

2011 episodes = 9; Total Savings = \$67,500

- Waiving three-day qualifying hospital stay keeping member in the long term care facility under an "In Lieu Of" (ILO) Day:

Cost Savings

Average hospitalization/ER/ambulance = \$7,500; Average ILO Cost = \$1,500

ILO Episodes in 2011 = 41

Average savings per episode = \$6,000; Total savings = \$246,000

- Covering programs such as medication therapy management:

Situation

Quality Initiative to perform medication reviews for long term care (LTC) members initially on nine or more medications due to their increased risk of adverse effects, drug interactions and increased cost of care, and now expanded to all LTC members.

Intervention

A pharmacist was hired to aid in this initiative. Med sheets were obtained and reviewed. Pharmacist met with nurse practitioners to discuss recommendations with three month follow up to review what changes were made as well as cost savings.

Cost Savings

2011 Cost savings = \$345,000

- Covering services such as on-site orthopedic care:

Situation

Fall/fracture occurs (collarbone, humorous, wrist) that would typically not require surgery

Intervention

X-ray at nursing home, ortho would access film digitally, physicians assistant would come on-site to treat, saving the disruption of ER visit and saving in ER cost and ambulance

Cost Savings

Average savings per episode = \$2,000 (ER/ambulance)

- Purchasing supplies and equipment that would not be covered under traditional Medicare/Medicaid funding:

Situation

Frequent dehydration/UTI/ER visits with certain non English speaking population living in Federal Housing building

Intervention

Standard procedure to purchase air conditioner and educate on hydration and nutrition

Cost Savings

Air conditioner cost - \$250; significant reduction in ER utilization saving the cost of an average ER/ambulance (\$2,000) for multiple community members

Est. 25 community members x 2 ER visits/year = \$100,000 savings

Page Three

The above examples reflect some of the positive outcomes that working with the MSHO program has provided for the dual eligible population we serve. If you have any questions, I would be happy to discuss other benefits to the members because of this program. Thank you for providing the opportunity to express our support of the State of Minnesota's proposal.

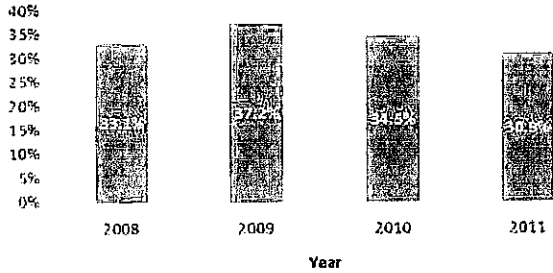
Sincerely,

A handwritten signature in black ink that reads "Julie Conrad". The signature is written in a cursive style with a large, looped initial "J".

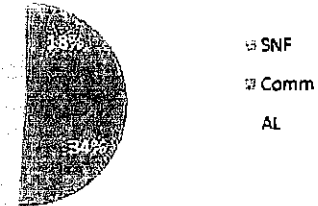
Julie Conrad
Vice President

FAIRVIEW PARTNERS 2011 SATISFACTION SURVEY

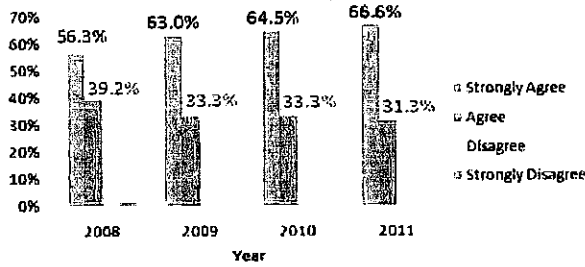
Response Rate
Year 2008 - 2011



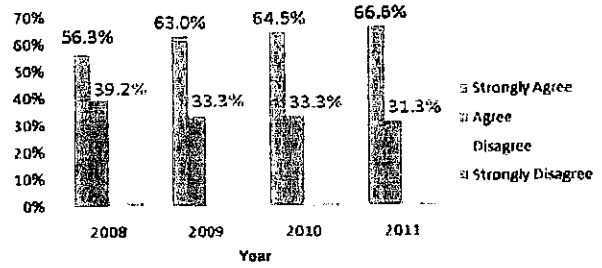
Who Responded
2011



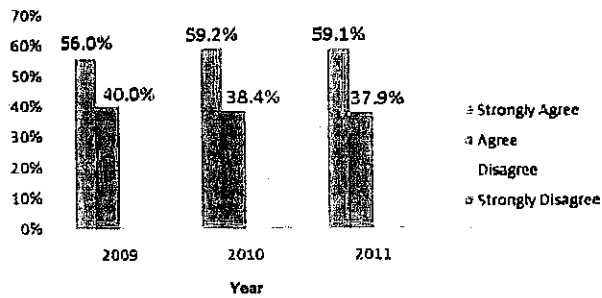
I am pleased with the quality of care I receive from my provider.
(Providers include: Fairview MD's, NP's, and/or CM's)



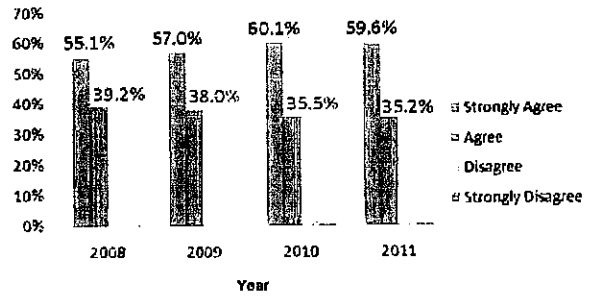
I am pleased with the quality of care I receive from my provider.
(Providers include: Fairview MD's, NP's, and/or CM's)



Overall, I am satisfied with the Fairview Partners program



I would recommend Fairview Partners to others



Fairview Partners Dual Demonstration Comments

Cost Shifting Concerns:

- Have experienced cost shifting from financing sources (health plans primarily) to providers especially in the area of administrative burden costs to manage the program. Also continue to see decrease in capitation rates to providers with increasing requests for higher administrative fees to health plans.

Financing Model:

- The capitation model can work as long as the capitation rate can cover the costs of these frail, high risk, high cost seniors.

Proposed Implementation Date:

- Is it reasonable to expect implementation in 2012 given there are still many undecided factors.

Frequent Regulatory Changes:

- Have experienced the negative impact of frequent regulatory changes and burdensome administrative requirements. This decreases the ability of providers to focus on patient care and drive up costs that do not directly benefit members.

Benefit Design:

- Benefit exceptions should lie closely with the patient/provider especially if benefit exceptions provide positive outcomes at less cost.

April 17, 2012

Mr. David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164-0983

RE: Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

Dear Mr. Godfrey:

We write in support of the Minnesota Department of Human Services' proposal to improve the integration of services for people who are dually eligible for Medicaid and Medicare services. We are especially pleased to see that people with disabilities, ages 16-64, are included in the target population.

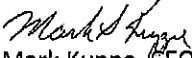
We've learned from the Kaiser Commission that about half of dual-eligibles ages 18-64 have a least one mental/cognitive condition; 72% have at least one physical condition; 3 of 5 have multiple chronic physical conditions; 2 of 5 have both a physical and mental or cognitive condition, compared to 17 percent of all other Medicare beneficiaries. There is great potential to improve care for, and thus the health status of, people who have psychiatric disabilities. Integrated financing is an essential step in reducing fragmentation and controlling costs.


As providers of community behavioral health services, we have a long history of experience and success in implementing "person-centered care". Community mental health work has always been collaborative with other organizations in the best interest of clients.

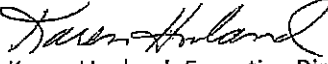
We welcome the opportunity to participate in Integrated Care System Partnerships and shared risk/gain arrangements. In so doing, Minnesota will capitalize on the experience and competence of specialty providers who address social determinants of health as well as physical and mental health conditions in an integrated and effective manner.

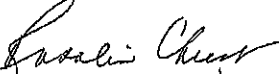
Thank you for your attention.


Sincerely,

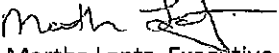

Mark Kuppe, CEO
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Rosalin Chrest, Executive Director
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Coon Rapids, MN 55433


Grace Tangjerd Schmitt, President
Guild Incorporated
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Martha Lantz, Executive Director
Touchstone Mental Health
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Minneapolis, MN 55414

Date: April 19, 2012

To: Pamela J. Parker
Purchasing and Delivery Systems
PO Box 64984
St. Paul, MN 55164

From: Patti Cullen, CAE
President/CEO
Care Providers of Minnesota
(952) 854-2844
pcullen@careproviders.org

Gayle Kvenvold
President/CEO
Aging Services of Minnesota
(651) 645-4545
gkvenvold@agingservicesmn.org

Re: Comments on State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery

The Long-Term Care Imperative is a legislative collaboration between Care Providers of Minnesota and Aging Services of Minnesota, the state's two long-term care trade associations. The Long-Term Care Imperative is pleased to have the opportunity to offer the following comments on the State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery. In general, our comments focus on how the demonstration will impact the provision of post-acute and long-term care services. While we view the demonstration as a potentially positive step toward improving outcomes and increasing efficiency for dual eligibles, we have a number of questions about how the demonstration will function that make us wonder whether all of its goals can be achieved.

Overall Response

As we said above, while the overall approach has merit and seems to offer significant improvement over the current Minnesota Senior Health Options (MSHO) model, (for example the potential for Medicare savings to be available to entities other than health plans), a number of questions about the proposal occur to us. How will payment rates for individual enrollees in the program be determined, and who is involved in that process? Is that part of the "three way agreement" between CMS, DHS and the managed care plans? The structure of those rates and the incentives they include will be hugely important to the success of the demonstration.

Other questions include how the transition from the current MSHO model will occur and whether individuals will be able to opt in to the new program as opposed to being passively enrolled into a demonstration? How will quality be measured and rewarded under the demonstration? Will those measures be determined by the Department of Human Services (DHS)

and CMS or by each managed care plan through the contract structure? What sort of transparency will there be in terms of how much the plans are being paid and how they use those resources?

An overall concern we have is the lack of focus on the long-term care services paid by Medical Assistance (MA). While this proposal builds on the many developments in primary, acute and post-acute care, some of which show great promise for improving outcomes and reducing costs, the proposal is largely silent on changes to the funding and provision of long-term care services. The financing of these services, and the incentives around that financing, are an area where this demonstration has the potential to greatly improve results for consumers and the efficiency of the use of state dollars.

Demonstration Proposal's Approach to Financing Services

We believe that overall there is likely enough total money in the current system, assuming you "count" acute, post-acute, ancillary, end of life and long-term care services, to effectively serve the dual eligible population, but current funding is poorly distributed and divided up between providers based on a "silo mentality" that does not focus on how to use resources to achieve the best outcomes. The demonstration has the potential to make great improvements in care if the financing is designed with incentives to provide the most appropriate and least costly option for each recipient. So, whenever it is appropriate the financing structure should encourage:

- The use of skilled nursing facility (SNF) or home care services as an alternative to more expensive hospital stays
- The use of assisted living services as an alternative to more expensive SNF services
- The use of a variety of community services as an alternative to assisted living

Rather than pursuing innovation, the current MSHO plans have relied on the restrictive and unimaginative nursing facility and Elderly Waiver Customized Living Workbook Medicaid rate systems. While there have been some achievements under the current program such as the occasional use of "in lieu days" and the waiving of the three day hospital stay requirement, the ongoing existence of service silos and lack of alignment of incentives means that there is the potential for much improvement in these areas.

On the long-term care side in particular, we believe that under the demonstration the state should look at some significant changes (Eliminating the 180-day cap on nursing facility liability, site neutral payment rates for both providers and for the managed care entities, and the elimination of restrictions on what MA dollars can be used for to meet resident needs to name a few) that can lead to better outcomes at lower cost. In addition, we need to point out that current MA long-term care services are significantly underfunded, so we believe that long-term care providers need to have a seat at the table as payment policies and rates are determined, so that some of the

greater efficiency in the use of resources can be captured to reward caregivers working in long-term care who are not adequately compensated under the existing financing models.

Provider Contracting and Risk/Gain Sharing under Integrated Care System Partnerships (ICSP)

While the assumption of risk can be useful in addressing the alignment of incentives in various parts of the health care system, the ability and willingness of providers to accept risk does vary quite a bit, especially on the long-term care side where the size of provider varies substantially. As a result, we recommend that the proposed demonstration be flexible enough to allow the option of risk-sharing or gain-sharing depending on the ability of various providers to assume risk. We would also encourage the state to require that the ICSPs, regardless of how they distribute risk and reward, include providers of post-acute and long-term care services as part of their structure and not just as contracted entities. Those providers need a seat at the table as the distribution of savings is determined.

We are also wondering about what role DHS expects to play in the contracting between managed care plans and ICSPs. Will they require that the managed care plans pay certain rates for certain services? Or that savings is distributed between providers in a certain way? Or that assumption of some risk is required to be part of an ICSP? These decisions are all important to the success of the demonstration, so while flexibility to try different models is important, DHS may need to have a role in this process to guarantee that consumers receive the best services provided as efficiently as possible.

State Use of Savings

The opportunity for the state to have a role in receiving some of the savings created under the demonstration is an exciting new opportunity. However, we hope that the state does not view their share of the savings as being used only to reduce state spending. Since most of the savings will come from Medicare, those savings could be invested in important needs without increasing the burden on state taxpayers. In fact, if the savings are invested wisely (i.e., in efforts to expand and improve services that reduce the use of more expensive services like hospitals or in Health Information Technology (HIT) for LTC) it could lead to greater savings in the future.

As we mentioned previously, current long-term care services are significantly underfunded with no plan in place to address the many needs, especially rewarding and attracting quality caregivers to provide these important services. Adequate and quality staffing will become even more important as these providers take on the challenge of providing more medically complex services for recipients with more complicated needs, and the savings these services generate should be recognized as one way of providing the funding to make system changes work. Ultimately, it may be that there are enough savings to make the needed investments and to

provide a reduction in state costs through the demonstration, but we would suggest that the initial priority should be on making crucial investments as opposed to realizing what would be only short term budget savings.

Barriers to Success of the Demonstration

While we believe that the proposed demonstration has a great deal of potential, there are a number of barriers on the LTC provider side that we see as potential issues that could limit the success of this project. As we have mentioned previously, current underfunding of LTC services means that providers have been challenged to maintain adequate staffing to provide current services. To the extent that a change in service patterns is needed to increase efficiency, which seems likely, then long-term care providers will need the resources to attract enough staff with the appropriate training. We also believe that an expanded HIT infrastructure will be crucial to effectively managing the transitions of care in a way that achieves the goals of the demonstration. Funding should be available, possibly through the ICSP structure, to develop the tools that will be needed in all settings to make the system work.

We also have some concerns about whether the model in this demonstration will work in all areas of the state. It seems like the ICSP model has less applicability in rural areas, where there is a limited number of providers. This raises some questions about what happens to providers who are not part of a network under the demonstration and whether that could become a threat to access in some areas.

It is also important to be aware that some of the most rural areas have the most inefficient service utilization patterns, in part because they may not have access to lower cost services such as assisted living or home care. We would like to see some sort of effort under the demonstration to try and address the need for a greater variety of service in the most rural areas of the state, which could potentially produce some savings while improving choices for consumers.

Outstanding Questions about the Demonstration

One concern we have about the demonstration as currently proposed is that some of the functional aspects of it are not clear yet. While we can see some ways in which it will be different than MSHO, we are wondering how different it will be and what the role of managed care plans will be under the demonstration. Will they be mostly an administrative unit dealing with enrollment and claims processing while providing some of the risk coverage, almost in a reinsurance role? Or will they have a much larger role in the coordination and management of services? The distinction between the plans and the ICSPs is not entirely clear in the proposal, perhaps because you are allowing some flexibility for models where the health plan has a bigger role and others where their role is more limited because the ICSP can do the care coordination and service provision?

The proposal is not clear in terms of how the per member per month payments will differ in their composition when compared to current MSHO payment design. How rates will be set and who will set them is also not clear, again perhaps because there will be some flexibility to use different models. It appears that the contract between CMS, the state and health plans will spell out some terms, but it is not clear if the per member per month rate determination will be part of that process or separate. The determination of service rates paid to providers, and who has a role in determining those rates, is even less clear at this point.

We also wonder about the role of counties under this demonstration. Can the existing county based purchasing entities be the managed care plan under this option, or will they cease to exist? If counties do wish to band together like they are able to now, do they have to take on the full risk (as they do in MSHO) or can they partner with a health plan to distribute that risk?

Also, we would like to point out one more time a few of our unanswered questions about the calculation and use of outcome data, the distribution of shared savings, and the role of long-term care providers in various aspects of the demonstration. We are hopeful that there will be positive answers to these questions that allow us to enthusiastically support the proposed demonstration, and as we said at the beginning it appears that this model improves on MSHO in some significant ways and we are very supportive of the implementation of a demonstration if it improves outcomes for consumers while using funds more efficiently and addressing some of the many challenges faced by providers.

From: Janny Brust [mailto:brust@mnhealthplans.org]

Sent: Friday, April 06, 2012 1:05 PM

To: Parker, Pam J (DHS)

Cc: *DHS_Dual Demo

Subject: State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery comments

State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery

The following comments are from the MN Council of Health Plans (MCHP) on the *State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery*. MCHP is a trade association comprised of Minnesota's non-profit health plans including Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan and UCare. MCHP and its members are dedicated to strengthening Minnesota's position as the nation's healthiest state by leading or supporting efforts, with community partners, that increase the value of health care services. Specifically, MCHP works to achieve high standards of quality care, broad access to health care coverage and services, affordable health care, as well as a climate that facilitates improvement in quality, access, and affordability.

MCHP and its members support demonstration programs, such as this "dual demo", that seek to improve care for seniors and people with disabilities who are dually eligible for both Medicare and Medicaid. MCHP, however, would like to address several policy issues related to this demo.

- **Financing:** Individual health plans need to understand the new CMS financing model before making a commitment to the demo. Health plans appreciate that DHS is trying to get additional information from CMS, but to the extent possible, individual plans need to have information as soon as possible as there is a significant investment in staff time to complete the application process. Additionally, individual plans will need to assess if the new payment system will be an improvement from the current Medicare Advantage payment system. If the new financial model does not seem feasible, individual plans may opt out which could impact access and the structure for how care is provided to the existing Minnesota Senior Health Options (MSHO) populations.
- **Partnership:** The demo supports a partnership among CMS, DHS and health plans. This is critical to the demo's success given the integration that is expected. Currently, the relationships are in silos. The plans would prefer to have a three-way collaborative relationship among plans, CMS and DHS in planning for this demo.
- **Regulatory authority:** DHS has stated that it will set financial and quality measurement parameters for the demo. However, health plans have existing relationships with care providers and would like to maintain some flexibility with those relationships in order to meet the needs of the individual health plan and the care provider. Because plans will primarily carry the financial risk, it's

critical that each health plan maintains flexibility in its relationship with the care provider.

- Clarification of demo components:
 - MOC and HSD tables: Health plans are required to submit Models of Care (MOC) and Health Services Delivery (HSD) tables to CMS in order to participate in the demo. Health plans continue to support the DHS proposal to “deem” health plans from both of these requirements for the following reasons:
 - All plans have already received MOC approval from CMS and NCQA.
 - All plans have demonstrated network adequacy already by being a participant in the State MSHO program.
 - If CMS does not deem, plans will need details as soon as possible on what and when information is needed.
 - Given CMS’ guidance that applicants will be able to request exceptions to CMS’ access standard under limited circumstances and that the exceptions approval process will be performed jointly by CMS and DHS, will you let plans know how this exceptions approval process will work? Two other suggestions: 1) Would DHS and CMS consider improving the exception process by creating a template with key components for the HSD tables? This would increase efficiency for health plans. 2) Would DHS and CMS consider allowing the same scoring for individual plans that choose not to modify a previously submitted MOC? Re-scoring would be done on individual plans who submit an enhancement.
- Process for Integrated Care System Partnerships (ICSP):
 - DHS plans to issue an RFP to promote more ICSP arrangements in the state. DHS recognizes that plans have existing alternative health care home (HCH) payment arrangements with providers and plans. DHS will need to evaluate the existing arrangements to determine if they meet basic ICSP Model 2 criteria. Plans believe that flexibility is needed in order to work creatively with providers for improved outcomes. Plans are concerned about any additional components that would be put in place if the State’s evaluation of existing arrangements doesn’t meet the RFP requirements. The concern is that this will add additional administrative burdens and may result in fewer providers participating in the MSHO program.
 - DHS refers to long term care providers, counties, tribes and HCDS being eligible to be ICSP sponsors. Will DHS provide additional clarification of the role of these providers in this model?
- Measurement: Will all health plans be required to use the same measures? Will it be possible for a health plan to have individual measures?

Thank you considering these comments. If you have questions, please feel free to contact me. Janny

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Blue Cross and Blue Shield of Minnesota
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800 382-2000



April 18, 2012

Deborah Maruska
Purchasing and Delivery Systems
P.O. Box 64984
St. Paul, N 55164-0984

Re: Comments in response to Draft CMS Design Proposal for Public Comment – Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

Dear Ms. Maruska:

Blue Cross and Blue Shield of Minnesota and Blue Plus appreciates the opportunity to respond to the Draft CMS Design Proposal for Public Comment – Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota which was published in the State Register on March 26, 2012 by the Minnesota Department of Human Services (DHS).

Blue Cross is the largest not-for-profit health plan in Minnesota, covering 2.3 million members. Blue Plus, the company's health maintenance organization, has participated in Minnesota Health Care Programs (MHCP) since 1993. With 123,099 members in the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare programs and 12,578 members in the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus programs, it is the largest health plan serving MHCP members in greater Minnesota. Blue Plus has been a participating plan in MSHO since the expansion of the statewide demonstration in 2005, and transitioned from a demonstration program to a Medicare Advantage Dual Eligible Special Needs Plan (MA-PD SNP) with the advent of Medicare Advantage and Part D.

Care coordination is a hallmark of MSHO (and MSC +). Since 2005 Blue Plus has delivered care coordination services primarily through contracts with local county agencies.. With the advent of state-based health care reform in 2008 and statewide certification of health care homes, Blue Plus began exploring alternative payment arrangements with providers in lieu of standard health care home care coordination fee payments for MSHO members. One alternative arrangement serving institutionalized MSHO members was in place in 2009 and 2010. Blue Plus continues to pursue alternative payment and other outcomes-based reimbursement models with primary care clinics for MSHO enrollees. These alternative payment arrangements for health care home and care coordination may also include risk/gain sharing arrangements with providers.

bluecrossmn.com

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Early alternative payment arrangements have provided information to improve on existing relationships and expand them to include other interested providers. We have also identified some of the challenges presented by such innovative models, including requirements relating to reporting of, and compliance with, provider incentive payment regulations as provided in Article 17.2 of our 2012 MSHO contract; accurate and affordable stop-loss arrangements to meet physician incentive plan requirements; and appropriate measures to support quality indicators and patient satisfaction and to deliver quality and value to enrollees. Next generation models are in development and will build on the lessons learned to date.

While Blue Plus anticipates receiving information regarding the financing model for the demonstration and understanding more about the integration of Medicare and Medicaid payment through the demonstration, Blue Plus submits the following comments for your consideration at this time:

H. Enrollment and Member Materials Integration

On page 10 of the Proposal, DHS proposes that for purposes of supporting the transition from the current SNP programs to the new demonstration, each current SNP member would get a notice from the State (or a joint notice from the State and CMS), informing them that the MSHO and SNBC programs would be moving to the demonstration and that enrollment in their current plan will continue without disruption and with no action on their part required. Blue Plus supports a seamless transition experience for each current SNP member. However, Blue Plus suggests that a notice to current members be developed by all of the parties to the demonstration and that health plans have an opportunity to review and comment on the proposed notice to members. Members know of their coverage through Blue Plus, and thus from a member perspective, we believe that a notice from all demonstration participants would be the most effective and beneficial.

K. Proposed Purchasing and Care Delivery Models

Minnesota has selected the Capitated Financial Alignment Model for purposes of the Demonstration. In this model, participating health plans are at risk for costs associated with the program.

The Demo Proposal sets out three proposed Purchasing and Care Delivery Models “under the umbrella of integrated Medicare and Medicaid financing created through the demonstration for MMICOs” to describe development of new provider payment and care delivery models. Two of these (the Primary Care Health Care Homes “Virtual Care Systems” and the Integrated Care System Partnerships) appear to be the most relevant to MSHO. As one or more of these Purchasing and Care Delivery Models are developed, it will be essential to take into consideration the risk already borne by program participants in the Demonstration.

Blue Plus supports the goals of payment reform and payment arrangements designed to achieve payment and delivery reform and to improve accountability for care outcomes across providers and care settings. Blue Cross Blue Shield of Minnesota has taken a leading role in

the implementation of aligned incentive contracting arrangements with several care systems in Minnesota which base a growing portion of provider payment on quality and cost-effectiveness. To ensure that this demonstration builds upon the value of these and other innovations, implementation must take into account the necessary flexibility needed for, and experience gained from, payment models already in place or in development as part of larger initiatives among health plans, care systems and participating providers. Criteria for payment reform, requirements relating to utilization of certified health care homes, primary care payment reforms and other components need to be developed in consultation and collaboration with health plan demonstration participants. The demonstration needs to be flexible enough to account for differences in provider relationships, contracts and health plan arrangements and to preserve member choice.

Under Model 1 Primary Care Health Care Homes “Virtual Care Systems”, the proposal notes that all enrollees would choose a primary care clinic, preferably a certified HCH where available. As the proposal notes, the state currently has 156 HCH certified, representing 25% of all primary care clinics in Minnesota. The proposal states that with the addition of another 150 currently in process, approximately one-half of all primary care providers in Minnesota will be certified. In this model, MMICOs would provide payments to HCH as currently required under MSHO/MSC+ contracts unless alternative payment models have been negotiated. Blue Plus again requests that the state develop criteria for Model 1 in consultation and collaboration with MMICOs.

Stating that “MMICOs would also be required to develop provider contract requirements that provide incentives to their participating clinics to become HCH” in order to facilitate member selection of certified health care homes may be disruptive to existing provider relationships. Extending provider incentives through requirements misses the mark for several reasons. First, provider contracts are frequently negotiated on a multi-year basis, with incentives and standardized performance measures that are developed over time. For providers willing to make the necessary investments in infrastructure to become a certified health care home, they will likely need incentives beyond the prospect of increased HCH payments. The scope of incentives needs to be tailored to individual relationships. Even if incentives were extended to some providers, there should be flexibility in the type of incentive and consideration given to the resources needed to implement such incentives.

Finally, this model is heavily dependent on appropriate communication tools. Some provider types listed (e.g., long-term care providers and home health agencies) are unlikely to have the electronic capabilities to implement or make use of these tools. Blue Plus supports the state’s efforts to work with stakeholder groups to promote these communications but recognizes that some components may not be applicable or viable in smaller independent practices as opposed to large health care systems. Appetite for risk sharing also significantly varies with provider type and size. Communication tools and strategies must also take into account applicable privacy and confidentiality restrictions.

In Model 2: Integrated Care System Partnerships the State proposes to issue an RFP for new facilitated contracting arrangements for integrated care system partnerships (ICSPs) serving seniors enrolled in the demonstration. These partnerships will involve providers and MMICOs in integrated delivery of primary, acute and long term care services. In addition, long term care providers, counties, tribes and HCDS would be eligible to be ICSP sponsors as well as primary and acute care providers. The proposal states that “DHS will use elements and experience from existing MSHO care systems and HCDS to build RFP requirements.” The proposal continues “[t]he RFP will specify parameters for standardized payment and risk/gain sharing arrangements that partnerships can choose, including flexibility for graduated levels of risk/gain sharing across services and standardized risk adjusted outcome measures, along with provider feedback mechanisms.” The proposal further states that “MMICOs will retain primary risk and thus will be part of the contract negotiations with ICSP providers in their networks.”

While this model proposes flexibility in arrangements with MMICOs, the description of the proposal appears inconsistent with that goal. Blue Plus needs to gain a better understanding of the level of risk involved, the amount of stop loss available for these arrangements, and the role of the “sponsor” in the proposed model. Blue Plus again requests that the state develop the RFP for such arrangements and payment models in consultation and collaboration with MMICOs. As the proposal indicates, MMICOs are expected to retain the primary risk in these arrangements; accordingly MMICOs need to be consulted regarding gain/risk sharing proposals and models. Without participation, consultation and collaboration with MMICOs, DHS could develop models that place a disproportionate amount of risk on the MMICOs without regard to the benefit. Moreover, Blue Plus needs more information from the State on its role in negotiating these arrangements with contracted plan providers. These may limit MMICO flexibility in developing pilot programs. The proposal also lacks specificity in the sponsor’s role in the model and what services would be included in gain/risk sharing arrangements. In addition, a risk model needs to clearly take into account the fact that enrollees may disenroll on a month to month basis. Finally, there is no limit on the number of ICSP participants; the greater the number of participants the higher the administrative costs of managing, tracking and evaluating the model.

We note that the proposal recognizes some of these issues in the discussion of barriers to implementation at Section V. (page 26) in which DHS acknowledges that while the goal will be to increase integrated Medicare and Medicaid financing arrangements, it is not yet clear how much risk and responsibility ICSP providers will be prepared to assume under the proposed subcontracts. Blue Plus appreciates DHS’ recognition of the need to take a flexible approach in developing these systems and again wishes to emphasize the need to include all participants in the demo in this discussion.

Blue Plus believes that purchasing and care delivery models developed pursuant to collaboration between all parties to the demonstration will provide the greatest opportunity for attaining greater coordination. When properly designed, these models are most likely to effectively leverage both provider capacity for effective care and utilization management and health plan capabilities in the realms of program management, customer satisfaction, and the

timely use of data and analytics. We believe that such a model will build on the inherent strengths of both the provider and the health plan through a shared competency approach, in which each organization's capabilities and expertise complement one another, drive incremental value, and incorporate the goals of the demonstration to provide payment and service delivery reform.

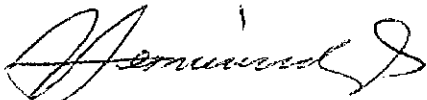
P. Medicare and Medicaid Data, Analytics and Capacity

On page 20 of the Proposal, DHS proposes to share its encounter data with CMS rather than having the MMICOs submit data to CMS. Blue Plus has significant concerns about this change. The State's proposed move to a data warehouse capable of accepting Medicare (Part C) data would duplicate Blue Plus' existing process for submission of Medicare data to CMS. Blue Plus has significantly invested in infrastructure to support submission of data to CMS and has worked directly with its own vendor to support this submission. Blue Plus has worked to establish a backend process to support reconciling the data to ensure that errors are worked and resubmitted. Moreover, because CMS is changing formats, there is a huge level of complexity to the back end process that still needs to be vetted. Not submitting our data to CMS would create break points in the process. From an Encounter Data perspective, we have serious concerns about this process. We suggest that plans have a choice, as they do today with respect to the TPA arrangement with DHS. In that case, we can contract with DHS to submit enrollment to CMS or we can submit on our own, provided we follow all CMS requirements.

Thank you very much for the opportunity to comment on the proposal. We appreciate the opportunity you have given us to be engaged in the discussion and development of this demonstration and look forward to further collaboration and participation in the future.

Please contact me if you have any questions.

Sincerely,



Frank Fernandez
Vice-President, Government Programs

Cc: Pamela Parker
Mark Hudson
Julie Stone
Alyssa Meller



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April 17, 2012

David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164-0983

Dear Mr. Godfrey:

HealthPartners is submitting this letter to the Minnesota Department of Human Services (DHS) in support of the draft proposal for a Medicare-Medicaid Integrated Financing and Delivery Demonstration under the Centers for Medicare and Medicaid Services (CMS) initiative "State Demonstrations to Integrate Care for Dual Eligible Individuals."

HealthPartners has over 25 years of experience serving Medicare and Medicaid beneficiaries and we are committed to continue serving this population. We originally served dual eligibles under the "Social HMO" demonstration in the 1980s. We then served dual eligibles under the CMS Medicare Advantage contract in conjunction with a state Medicaid contract. We began our Minnesota Senior Health Options (MSHO) dual-eligible program in 2005 and today we have over 2,900 MSHO members. We strive to simultaneously achieve the Triple Aim goals in our work to improve the health and experience of our members and the affordability of health care.

HealthPartners has achieved outstanding results in serving this population. Some examples of this include:

- Best HEDIS performance compared to other Minnesota plans in seven measures;
- Highest Model of Care rating with a three-year approval from NCQA and CMS;
- Innovative care model designs and partnerships with providers such as Presbyterian Homes and Amherst H. Wilder Foundation;
- Palliative care program to enhance in-home care coordination for frail and seriously ill members who have chronic and/or serious life-limiting illnesses;
- Reductions in total hospital admissions and antipsychotic use for those in long term care facilities.

David Godfrey
April 17, 2012
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We support the overall goals of this demonstration proposal that integrates Medicare and Medicaid benefits and service delivery with a focus on person-centered care coordination. This integration of programs is important in order to offer and achieve a seamless experience for dual-eligible seniors and people with disabilities.

HealthPartners needs to learn more about key demonstration components, such as the payment model, withholds and quality performance measurement. We support the demonstration as an opportunity to continue to support and achieve The Triple Aim for dual-eligible beneficiaries building off the significant successes of the Minnesota Senior Health Options Special Needs Plan. We look forward to working with DHS and CMS to finalize the components of the Demonstration and continue to improve care to dual-eligible beneficiaries.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer J. Clelland". The signature is fluid and cursive, with a large initial "J" and "C".

Jennifer J. Clelland

Sr. Director, Government Programs

HealthPartners

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April 18, 2012

Deborah Maruska
Purchasing and Delivery Systems
Minnesota Department of Human Services
PO Box 64984
St. Paul, MN 55164-0984

Dear Ms. Maruska:

HealthPartners is submitting these comments to the Minnesota Department of Human Services (DHS) in response to the Draft CMS Design Proposal for Public Comment: Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota, known hereafter as the Demonstration, published in the State Register on March 19, 2012.

HealthPartners has over 25 years experience serving Medicare and Medicaid beneficiaries and we are committed to continue serving this population. We originally served dual eligible beneficiaries under the "Social HMO" demonstration in the 1980s. We then served dual eligible beneficiaries under a CMS Medicare Advantage contract in conjunction with a state Medicaid contract. We began our Minnesota Senior Health Options (MSHO) program in 2005 and today we have over 2,900 MSHO members. We strive to simultaneously achieve the Triple Aim goals in our work to improve the health and experience of our members and the affordability of health care.

HealthPartners has achieved outstanding results in serving this population. Some examples of what HealthPartners has accomplished under the current MSHO program include:

- Best HEDIS performance compared to other Minnesota MSHO plans in seven measures;
- Highest Model of Care rating by NCQA and CMS, with a three-year approval;
- Innovative care model designs and partnerships with providers and the long term care community, such as Presbyterian Homes and Amherst H. Wilder Foundation;
- Reductions in total hospital admissions. Reductions in Re-admissions for long term care members. Significant focus on reduction of antipsychotic use for members in long term care facilities;
- Palliative care program to enhance in-home care coordination for frail and seriously ill members who have chronic and/or serious life-limiting illnesses.

We support the overall goals of this Demonstration proposal to integrate Medicare and Medicaid benefits and service delivery with a focus on person-centered care coordination. This integration of programs is important in order to offer and achieve a seamless experience for dual eligible beneficiaries.

Deborah Maruska

April 18, 2012

Page 2

Any consideration of the Demonstration needs to be done in the context that Minnesota has already achieved significant advancement in coordinating care for dual eligible beneficiaries. Minnesota has benefitted from the State's early vision and leadership in this area and we have grown to establish a mature program for dual eligible beneficiaries. Minnesota began its original dual eligible demonstration in the 1980s and then was able to optimize the federal implementation of Special Needs Plans and Pharmacy Part D services under Medicare. This resulted in the original demonstration transforming into a federal Medicare Special Needs Plan in conjunction with an integrated State Medicaid contract in 2006. We understand that there continue to be opportunities for improvement in serving dual eligibles and we are committed to continuing to improve care and service.

Because of Minnesota's unique position in serving dual eligibles with innovative programs over the years, it is doubly important that the Demonstration is able to support continued improvements and innovations, and doesn't have the unintended consequence of reversing the sophisticated program currently in place. In light of this, HealthPartners recommends an implementation date of January 2014 for the Demonstration. The CMS Demonstration opportunity is focused in large part on states new to integrated programs for dual eligibles. A 2014 start to the Minnesota Demonstration will allow Minnesota to focus the Demonstration implementation on what Minnesota uniquely requires to optimize the next evolution of improvements for the care of dual eligibles on a current, sophisticated program base.

In addition, full consideration of the Demonstration includes a Triple Aim comparison of the current Minnesota Senior Health Options program to the Demonstration. At this time, there is critical information not yet available about the Demonstration. We advise that the State have full information in order to complete a decision about pursuit of the Demonstration. We consider the following information critical to evaluation of and a final decision regarding the Demonstration:

- CMS payment methodology and the required savings;
- Quality performance goals and reporting measures;
- Performance withhold goals;
- Health Care Home expectations for providers serving dual eligible beneficiaries;
- ACO and care delivery design and expectations;
- Role of Medicare Part D in the Demonstration, including the interplay of bids, reports, costs, star ratings, and audits;
- Enrollment design of the Demonstration.

Deborah Maruska

April 18, 2012

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HealthPartners has an extensive history of participating in federal and state demonstrations and there is support for utilizing demonstrations as a vehicle to pilot, test, and achieve care transformation and payment reform. As a result of this history and experience, HealthPartners understands the importance of analyzing basic demonstration components in order to assure that a demonstration has the critical success factors to achieve the Demonstration goals.

The following critical success factors are important to the success of the Demonstration:

- Sustainable payment model. If the Demonstration proceeds for January 2013, the most effective starting point is to utilize the 2013 Medicare Advantage risk-adjusted bid payment and then any additional changes to the payment can be made for 2014 and beyond.
- Support and flexibility for continued marketplace innovation in care transformation and payment reform;
- Support and flexibility for provider care systems to test, pilot, and implement care innovation;
- Encouragement for enhanced provider partnerships including long term care providers;
- Robust provider participation. The Demonstration needs to maintain the current range of providers involved in a dual eligible program. The strength of the current program has been that it has involved a broad set and variety of providers, includes them in their current capacity and then engages them in new partnerships, care models, and care transformation based on what works best for the members, providers, and plans. This approach has helped the whole community participate in serving dual eligible beneficiaries and work together to improve care and service.
- Outcome and improvement goals that are attainable and permit flexibility in the pathway for how plans and providers attain these goals. Flexibility rather than prescriptiveness is a key critical success factor, for example, in the areas of: provider communication and care plan communication; requirements for care systems, the ACO model, and/or any Health Care Home requirements; risk and gain sharing partnerships with providers. To support and achieve care transformation, we have found it very effective to provide attainable goals using community measurement, and offer suggestions and technical assistance if the provider is interested.
- Take a new look at what reporting measures and quality performance goals are required for the Demonstration. First, evaluate all current Medicare Advantage Part C and Medicaid requirements to determine which ones apply to the Demonstration and which ones can be eliminated. Secondly, determine if new measurements are necessary. For example, evaluate if the STARS and Structure and Process measures will apply to the Demonstration.
- Integration of key member components of the MSHO program such as member materials, appeals and grievances, the enrollment form, claims payment, quality goals, quality performance measurements, and reporting.

Deborah Maruska

April 18, 2012

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- Clear designation about the enrollment function. If it is determined that enrollment will be performed by the State for the Demonstration, then CMS oversight of that function directly with DHS will achieve the clearest accountability.
- MN currently has a strong model for dual eligibles. While this Demonstration certainly offers more opportunities for partnerships with providers, we think many or all of these goals can be achieved under the current model.

In summary, HealthPartners recommends:

- Full evaluation of the Demonstration components to complete a decision about pursuit of the Demonstration;
- A January 2014 start date for the Demonstration;
- Using the CMS Medicare Advantage Special Needs Plan (SNP) bid payment for the first year;
- Focus on articulating outcome and improvement goals for the demonstration and providing flexibility for care model innovation, payment reform, and tests of change.
- Integration of key components such as member materials.

The current Minnesota Senior Health Options program is strong and successful. If the Demonstration is not pursued, HealthPartners is very willing to invest in supporting and achieving the State's goals for dual eligible beneficiaries under the current program.

HealthPartners supports the Demonstration as an opportunity to continue to improve the Triple Aim results for dual eligible beneficiaries in Minnesota. We look forward to partnering with DHS and CMS to finalize the components of and decision about the Demonstration and will continue to invest in care transformation and improved outcomes for dual eligible beneficiaries.

Thank you for your consideration of these comments.

Sincerely,



Jennifer J. Clelland

Senior Director

Government Programs



April 25, 2012

David Godfrey
Minnesota Medicaid Director
PO Box 64983
St. Paul, MN 55164-0983

Re: Letter of Support

Dear Director Godfrey:

Metropolitan Health Plan (MHP) supports Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota to improve care for seniors and people with disabilities. Combining service delivery for Medicare and Medicaid through integrated financing provides platform for aligning operational and financial incentives between Medicare and Medicaid pharmacy, primary, acute, post acute and long term services.

Under this capitated financial alignment demonstration, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS) and Managed Care Organizations (MCO's), like MHP, will test a new payment and service delivery model to reduce program expenditures under Medicare and Medicaid, while enhancing the quality of care to these dually eligible enrollees. The three-way contracts will assess administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Minnesota's Medicare and Medicaid enrollees.

Sincerely,

Karen A. Sturm, Interim CEO
Metropolitan Health Plan

Health. Care. Respect.

April 13, 2012

Pamela Parker
Director of Integrated Purchasing Demonstrations
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101

Medica Health Plan has been a long time partner with the Minnesota Department of Human Services in serving the dual eligible population. Medica was one of the founding plans of the Minnesota Senior Health Options (MSHO) demonstration in the late 1990s. With the State of Minnesota, Medica transitioned the demonstration to a Medicare Advantage Special Needs Plan in 2005 and continues to serve dual eligibles through the MSHO program today.

Medica staff is concerned that the current Medicare Advantage Special Needs Plan platform is not stable and will be unable to support the MSHO program in the future. We applaud DHS in its forward thinking to explore this demonstration offered by Centers for Medicare and Medicaid Services' (CMS) Office of Medicare and Medicaid Integration.

The following comments are made from review of the Draft CMS Design Proposal for Public Comment: Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota issued on March 22, 2012.

Medica appreciates the program enhancements the demonstration may provide. We support the following aspects of the proposal:

- Ensuring dual eligible seniors can continue to participate in a fully integrated program designed to meet their needs.
- Creating an opportunity to focus on more age-appropriate outcome measures than current SNP platform allows.
- Working towards improved, simplified member materials to help program participants understand their benefits and options better
- Facilitating improved state and federal collaboration that will allow for the MSHO program to evolve gracefully into the future landscape of health care and service delivery.
- Creating a new opportunity for health plans and providers to test alternative payment methodologies that result in improved program participant experiences and outcomes.
- Improving plan administrative requirements by streamlining data submission needs.

Though Medica is in support of innovation and program evolution, areas of the demonstration proposal that raise concern are:

- Financing of the demonstration. We appreciate that DHS and CMS are still working on this aspect of the proposal and recommend the following:
 - Total financial models are shared with the Plans as soon as possible to allow

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and Medicaid Plans

- evaluation of the viability of the programs.
 - The capitation rate is based on total benefit coverage and adequate baseline spending projections. Utilization and costs are captured and reviewed in aggregate treating the program as an integrated product.
 - Truly treat as an integrated product despite separate payment funding streams from CMS and DHS. Funding payment streams to be determined between CMS and DHS without splitting integrated claims data
 - Underlying benchmark data properly addresses the Physician cuts not in effect (to not penalize MCO rates)
 - Member/Plan risk scoring is adequate for this high risk frail population (inclusion of necessary frailty factors)
 - Consideration for Minnesota's advanced program is applied in savings targets
 - Unified mechanisms exist between CMS and DHS for withholds, reporting and shared savings determination
 - CMS Part C data reporting and data validation efforts are excluded or suspended for the demo
- While we recognize the benefit of our members choosing a Health Care Home certified provider organization, the requirement that plans incent all providers to become HCH certified is concerning. Some providers may not be ready for HCH certification even though they provide an excellent care to their members. We are concerned that over time members will be asked to disrupt their care to choose a new provider because their current one is not part of a HCH.
- We would like to understand more about the process for Integrated Care System Partnerships (ICPS). We appreciate that DHS recognizes that plans like Medica have long standing alternative health care home (HCH) payment arrangements with providers. Medica would like to better understand what DHS will be evaluating within the existing arrangements to determine if they meet basic ICSP Model 2 criteria. We are concerned about the possible modifications that may be required if the State's evaluation of existing arrangements doesn't meet the RFP requirements. These modifications may result in fewer providers participating in the MSHO program and care disruptions for our members. Our experience strongly suggests that flexibility is needed in order to work creatively with providers for improved outcomes and recommend that DHS be open to considering a number of options.
- There is concern about the viability of returning SNBC to an integrated program. Plans have invested significant effort and resources to get this option to work. Significant financial and operational changes would need to be made to reconsider this option. Additionally, the quick timeline for the SNBC-eligible Minnesotans to transition into health plans in 2011 has been challenging for members and plans alike. We suggest any major changes to this program would be done within reasonable timelines.
- We agree that there is an opportunity for improved communication and hope that whatever enhancements or standards DHS pursues for the Virtual Model, that they will take existing IT infrastructures of the plans and their community based (counties and community agencies) into consideration.

We look forward to continuing the discussion with the Department of Human Services and Centers for Medicare and Medicaid Services staff regarding this demonstration in the hope of finding a long term solution for our members served by this important program.

Sincerely,

A handwritten signature in black ink that reads "Julie C. Faulhaber". The signature is written in a cursive, flowing style.

Julie C. Faulhaber
Senior Director, State Public Programs



April 13, 2012

David Godfrey
Minnesota Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear David:

I write this letter to conditionally support the Department's March 22, 2012 proposal to re-design integrated Medicare and Medicaid financing and delivery for dual eligibles (the capitated financial alignment demonstration, or dual demonstration). As we know, since 1997 Minnesota has been leader in integrated, person-centered care for duals (seniors, then individuals with disabilities), and UCare certainly supports the principles and goals of the dual demonstration.

There is much to support in your draft proposal – forward thinking service delivery models, a CMS/DHS integrated materials review process, retaining the integrated appeals and grievances process, and seamless transfer of current MSHO members/opt-out enrollment process for current MSC+ members.

Although UCare supports the goals of the dual demonstration, like the Department, we have some outstanding areas of significant concern where clarifying guidance is essential – chief among them whether there is to be a viable financial model. Without workable finances, UCare does not see how we could support moving from our current SNP model to a demonstration model.

Other areas of concern include the requirement to submit HSD tables, our desire to maintain current contracting relationships with care providers, the sense that CMS is not recognizing the current SNPs versus what might be expected of a new plan, and the enormity of work that will be required to submit a dual demonstration application by May 24th.

We look forward to continuing the conversation with the Department and CMS and hope that our concerns will be addressed in the very near future.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Ghita Worcester'.

Ghita Worcester
Senior Vice President
Public Affairs and Marketing



April 19, 2012

Deborah Maruska
Purchasing and Service Delivery
Health Care Purchasing
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

Dear Deb,

Please see the attached UCare comments on the Minnesota Department of Human Services' proposal to the Centers for Medicare & Medicaid Services (CMS): State Demonstration to Integrate Medicare and Medicaid Benefits and Service Delivery.

While we have a number of outstanding questions about this demonstration, many of which will need to be responded to by CMS, we appreciate DHS' efforts to pursue a stable platform for Minnesota health plans to continue offering integrated products to Minnesotans who are eligible for both Medicare and Medicaid services. Through 15 years of experience, we firmly believe this is ultimately the most member-friendly, high-quality and efficient way to deliver health care services to these individuals.

Thank you for your ongoing work in this area. We look forward to continuing work on this project.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Ghita Worcester'.

Ghita Worcester
Senior Vice President
Public Affairs and Marketing

Attachment: 4/19/12 UCare comments to DHS proposal

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>A. Introduction: Issues for People with Dual Eligibility for Medicare and Medicaid</p>	<p>UCare, along with other health plans represented by the Minnesota Council of Health Plans, support demonstration programs, such as this “dual demo,” that seek to improve care for dually eligible seniors and people with disabilities. However, there are a number of overarching concerns about the demonstration that need to be addressed quickly, given the aggressive DHS/CMS timelines, including information about demonstration Medicare financing, creation of a meaningful three-way partnership (CMS, DHS, the health plans), and concerns about potentially excessive regulatory authority/involvement in health plan provider contracting activities. For more information about these three items, please see below.</p> <p>Financing:</p> <p>1. Individual health plans need to receive information about, and fully understand, the new CMS financing model before committing to participating in this demonstration. We appreciate that DHS is attempting to get additional information from CMS, but to the extent possible, individual plans need to have information as soon as possible before we can be expected to make the up-front significant investment in staff time to complete the application process.</p> <p>2. Additionally, individual plans will need to assess if the new payment system will be an improvement from the current Medicare Advantage payment system. If the new financial model does not seem feasible, individual plans may opt out and this could have a direct impact on how individuals with Medicare and Medicaid in Minnesota access services and the structure under which these individuals access services today under Minnesota Senior Health Options (MSHO).</p> <p>Partnership: The demonstration portends a partnership between CMS, DHS and health plans. This is critical to the demonstration’s success given the integration that is expected. Thus far, the planning process and relationships are still very much in silos. UCare is requesting that the three-way collaborative relationship for planning for this demonstration occur.</p> <p>Minnesota health plans have a long tradition of working closely with the state and with each other that has allowed for streamlined processes and integration of systems and member materials that has withstood the test of time and been a valuable model for national integration programming.</p> <p>Regulatory authority: DHS has stated that it will set financial and quality measurement parameters for the demonstration. However, health plans have existing relationships with care providers and need to maintain a certain degree of flexibility in maintaining their provider relationships in order to meet the needs of each health plan, care providers, and ultimately their members. This is especially important given that the health plans will carry the financial risk in these relationships.</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>D. Demonstration Parameters</p>	<p>1. Regarding the statement that CMS has authority to make successful demonstrations permanent, we suggest that this language be stricken. We are not aware of authority permitting CMS to make the demonstrations permanent. <i>See also</i> Section G, last paragraph.</p> <p>2. In the paragraph at the bottom of page 2, we think that you mean to say "... and negotiate three-way contracts"</p> <p>3. Health plans are subject to significant payment withholds under the DHS contracts, and we would be concerned about the establishment of additional withholds being applied to Medicare revenues. With respect to withhold measures in general, we support the application of meaningful, appropriately scaled withhold measures.</p> <p>4. We think it is important for CMS to recognize the limitations of garnering very much of the savings that would typically be attributed to newly implementing managed care given the mature market that exists in Minnesota, including the market for services in managed care.</p> <p>5. We greatly appreciate the opportunity to continue integration of administrative and operational product features for MSHO. These often are the features that make this product more member and provider friendly. As part of the demonstration, we would want to look for more opportunities to increase efficiencies that benefit all stakeholders: members, families, providers, plans, state and federal partners.</p>
<p>G. Experience with Previous Demonstrations and Medicare Advantage Special Needs Plans</p>	<p>In the second paragraph, we suggest that the third sentence be amended as follows: Congress must reauthorize CMS authority for all SNPs before the end of 2012 <u>by the end of the first quarter of 2013</u> in order for D-SNPs to continue. [We think that MAOs could submit 2014 bids if authority was re-authorized as late as early 2013].</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>H. Enrollment and Member Materials Integration</p>	<ol style="list-style-type: none"> 1. In the first full paragraph on page 10, we think that DHS means to say: " ... and that enrollment in their current plan will continue without disruption" 2. We believe the facilitated enrollment of newly dual eligible aged members directly into MSHO (with an opt-out option) would direct individuals to the best available product at the front end. We also support the approach being proposed by DHS that maintains member choice by allowing individuals to opt-out of MSHO and enroll into Minnesota's non-integrated managed care product for seniors (MSC+). 3. We support maintaining and improving upon the current integrated materials review process. 4. Due to practical Minnesota-specific concerns/timelines, we support the state's request to establish separate mailing timeline requirements for the MSHO ANOC and EOC. We understand CMS is reviewing the D-SNP 2013 timelines. 5. We support the idea of having a single CMS reviewer for Minnesota's integrated plans' member materials. 6. Member materials already approved by DHS and the CMS Regional Office under this coordinated integrated member materials review process be utilized for the demonstration. 7. CMS move current approved materials from current "H" numbers to new "H" numbers under the demonstration. 8. Improvements in the timelines and the review process for materials, such as shortening the time period for review when state model materials approved by DHS and CMS are used by all participating health plans. 9. Exploring with CMS the possibility of improving materials used for Part D, e.g., adding language about Medicaid formulary wrap-around coverage. 10. That standardized forms currently required by Medicare for skilled nursing denials not be used. 11. That CMS defer Medicare language block requirements to DHS so that the needs of Minnesota's (and other states') unique population mix be recognized. This issue is highlighted by the fact that the new Medicare SNP requirements exclude five of the most used languages in Minnesota such as Somali and Hmong, but include other languages not prevalent in Minnesota.

UCare Comments on DHS Dual Demonstration

Section	Comments
J. Provider Networks	<p>1. UCare continues to strongly support DHS' proposal to "deem" health plans as currently meeting Medicare access requirements because all health plans currently demonstrate network adequacy by virtue of participating in the current D-SNP MSHO program. However, at this point, CMS guidance requires plans to submit full HSD tables to CMS in order to participate in the demonstration.</p> <p>As recently as March 2012, Minnesota D-SNP health plans believed their existing networks would be deemed as adequate based on existing SNP status. Without CMS deeming, plans will need to expend significant (unplanned) resources to prepare HSD tables, a process most organizations would plan ahead for at least 12 months in advance. We suggest that DHS' proposal to CMS continue to stress the need to deem existing Minnesota D-SNP networks, at least for one year, to allow time for health plans to fulfill CMS' robust network requirements. In the alternative, we request that current SNPs be permitted to submit just core provider and facility table elements (e.g., county, name, NPI, address, specialty) to demonstrate core network adequacy for the application. The other indirect data requested is much more difficult to gather and validate and has much less bearing on the availability of providers.</p> <p>2. Given CMS guidance that applicants will be able to request exceptions to CMS access standards under limited circumstances and that the exceptions approval process will be performed jointly by CMS and DHS, we are requesting a description of how this exceptions approval process will be carried out between the health plans, DHS and CMS. We encourage streamlining of this process given the expected tight timelines.</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>K. Proposed Purchasing and Care Delivery Models (See Related Purchasing Models Chart Appendix 1).</p>	<p>1. UCare is most concerned about the ongoing impact of lack of CMS adjustment to Medicare Advantage rates related to the physician sustainable growth rate (SGR).</p> <p>2. We are apprehensive about adoption of state defined risk sharing models given the lack of information about the Medicare payment model under the demonstration and Minnesota's historically low Medicare Advantage reimbursement rates. Due to each health plan holding the demonstration's full financial risk, the provider selection/decisions to take on risk with the demonstration must be balanced with the need for financial viability for the overall health plan product.</p> <p>3. UCare is also concerned about seemingly increased levels of regulator involvement and/or regulator-driven requirements being imposed upon health plan providing contract arrangements. Provider contracting with systems is a relationship that includes all products offered and should remain driven by the health plan and provider. A "one size fits all" model is not appropriate for provider contracting models.</p> <p>3. UCare is aware of a historical lack of provider interest in assuming down-side risk in contracting arrangements and questions whether providers will want to assume risk under the dual demonstration.</p> <p>4. UCare is appreciative that DHS will include health plans in efforts to develop meaningful outcome measures appropriate for the demonstration population(s). We look forward to participating in this process and working with DHS, CMS and other health plans with the goal of developing evidence-based measures to will improve member care and establishing realistic, scalable thresholds.</p>
<p>K. Proposed Purchasing and Care Delivery Models a) <u>Care Coordination</u></p>	<p>1. UCare appreciates that CMS recognizes the Minnesota D-SNPs have existing, approved Models of Care (MOC) and is allowing Minnesota D-SNPs to submit their MOC to meet demonstration requirements.</p> <p>2. UCare looks forward to working with DHS, other health plans and CMS on improving coordination and integration are care across the continuum of providers/services, including long term care services (nursing home and waiver services) and behavioral health services.</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>K. Proposed Purchasing and Care Delivery Models b) Service Delivery Models - Model 1. Primary Care Health Care Homes "Virtual Care Systems".</p>	<ol style="list-style-type: none"> 1. UCare requests that DHS support MMICOs in working with primary care clinics under Model 1 by requiring that new Minnesota Health Care Programs enrollees identify or choose a primary care clinic at the point of application for enrollment. 2. Will the incentives that DHS expects to be added to MMICO provider contracts to encourage primary care providers to become health care homes be acknowledged in rate setting for the dual demonstration? 3. UCare will continue to participate in DHS collaborative meetings aimed at improving communications and clarifying roles between various care coordination entities and health care homes.
<p>K. Proposed Purchasing and Care Delivery Models b) Service Delivery Models - Model 2. Integrated Care System Partnerships (ICSPs)</p>	<ol style="list-style-type: none"> 1. UCare requests that DHS support MMICOs in working with primary care clinics under Model 2 by requiring that new Minnesota Health Care Programs enrollees identify or choose a primary care clinic at the point of application for enrollment. 2. DHS notes that HCDS experience will partially inform the development of the ICSP model, but the HCDS agreements are not in place, the HCDS model in some cases will focus on a much younger and healthier Medicaid population, and, even in the best case scenario, this model unlikely to be operational for long enough to inform a January 2013 ICSP RFP. 3. UCare requests that DHS clarify the role of the ICSP sponsor.
<p>K. Proposed Purchasing and Care Delivery Models b) Service Delivery Models - Model 2. Integrated Care System Partnerships (ICSPs) - Current Care Systems with Alternative HCH Payments</p>	<p>Health care home activity is still at modest levels. How will DHS work with the Department of Health to encourage more providers to become certified health care homes?</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
K. Proposed Purchasing and Care Delivery Models <u>b) Service Delivery Models Model 3. SNBC Chemical, Mental and Physical Health Integration Partnerships</u>	<p>The PIN model currently operational in Dakota County serves approximately 300 individuals. Has this model proven to be scalable statewide to the numerous SNBC enrollees with behavioral health disabilities?</p>
K. Proposed Purchasing and Care Delivery Models <u>c) Evidence Based Practices.</u>	<p>UCare is appreciative that DHS will include health plans in efforts to develop meaningful outcome measures appropriate for the demonstration population(s). We look forward to participating in this process and working with DHS, CMS and other health plans with the goal of developing evidence-based measures to improve member care and establishing realistic, scalable thresholds.</p>
L. Benefit Design - People with Disabilities	<p>UCare is dedicated to offering viable health care plans to people with disabilities. That being said, and given UCare's considerable experience with products that integrate Medicare services, UCare would need to carefully study any proposed CMS Medicare reimbursement model(s) before committing to developing/offering a Medicare plan for people with disabilities. Our goal would be to ensure UCare could successfully deliver a quality, sustainable product to our members that is financially viable over time.</p>
M. Financing and Savings Model / N. Payments and Rates	<ol style="list-style-type: none"> 1. Individual health plans need to receive information about, and fully understand, the new CMS financing model before committing to participating in this demonstration. We appreciate that DHS is attempting to receive additional information from CMS, but to the extent possible, health plans need to have information as soon as possible before they can be expected to make the up-front significant investments in staff time to complete the application process. 2. Additionally, individual plans will need to assess if the new payment system will be an improvement from the current Medicare Advantage payment system. If the new financial model does not seem feasible, individual plans may opt out, which could impact access and the structure for how care is provided to the existing MSHO populations.

UCare Comments on DHS Dual Demonstration

Section	Comments
O. Measurement, Evaluation and Outcomes	Will all health plans be required to use the same measures? Will it be possible for a health plan to have individual measures?
P. Medicare and Medicaid Data, Analytics and Capacity	UCare supports the concept of submission of encounter data to DHS and CMS in a standard format with standard editing. If possible, having the data submitted through DHS, to CMS, should be considered.
Q. Enrollee Protections	<p>UCare supports DHS' interest in having a single version CAHPS survey administered by the state to eliminate duplication between the federal and state survey.</p> <p>UCare values direct input from members. Given the average age of MSHO members being over 80 and the difficulty MSHO members might have getting to/participating in meetings, we suggest the state consider a) expanding representation of an MSC+/MSHO advisory group to include advocates/representatives for our more frail elderly and/or institutionalized members, b) allowing health plans to broaden existing stakeholder advisory groups to include senior MSHO/MSC+ members, and/or c) DHS coordinating a seniors managed care beneficiary advisory group in which all the MCOs could participate.</p>
R. Legislation Required or Medicare and Medicaid Waivers Requested	UCare shares DHS' concern about the ability for established MSHO plans to seamlessly revert to D-SNP status for 2013 if the three-way contracting process does not produce a workable agreement. With the aggressive timeline for the demonstration, and both the dual demo and standard D-SNP bidding moving forward simultaneously, this ability to seamlessly revert to D-SNP status for 2013 will be critical for ensure continuity of coverage for current D-SNP enrollees.
Transition back to SNP status if needed	As noted earlier, in the event that there is agreement among all parties that the demonstrations are not viable, UCare supports the DHS request for assurances from CMS that CMS would facilitate transitions of demonstration plans back to SNP status to avoid disruptions in long standing integrated care arrangements.
S. Relationship to Existing Waivers and Service Delivery Initiatives: <u>c) Behavioral Health Plans:</u>	UCare supports efforts aimed at improving treatment of medical conditions that often go untreated in people with mental illness.

UCare Comments on DHS Dual Demonstration

Section	Comments
S. Relationship to Existing Waivers and Service Delivery Initiatives: <u>d) Integrated SNP or PACE programs</u>	<p>If this demonstration is to proceed, UCare supports DHS' proposal that current contracted SNPs become MMICOs and operate under the demonstration and that current enrollees be seamlessly transitioned into the new integrated demonstration plans.</p>
U. Summary of Stakeholder Involvement	<p>UCare supports, and participates in, many DHS stakeholder opportunities, including both the Seniors Managed Care Stakeholder Advisory Committee and the Stakeholder Advisory Committee for People with Disabilities in Managed Care.</p>
V. Feasibility and Sustainability - Discussion of Barriers to Implementation	<p>UCare agrees with the DHS assessment that provider willingness to assume financial risk is a major prerequisite for the successful implementation of the ICSP model.</p>
W. Implementation and Timelines	<p>The timelines for the dual demonstration are, to say the least, aggressive, given the fairly recent CMS issuance of guidance about the requirements for the demonstration. We do not think states that entered into the \$1 million grants/contracts with CMS for improving integration of care for dual eligibles well ahead of the CMS notice of the dual demonstration should be required to implement dual demos on such short timelines. This occurs at considerable up-front administrative expense to the plan applicants, with such efforts happening without information on the Medicare financial model (other than a requirement for shared savings and new Medicare withholds).</p>

UCare Comments on DHS Dual Demonstration

Section	Comments
<p>X. Interaction with other HHS Initiatives <u>(a) Million Hearts,</u> <u>(b) Partnership for Patients,</u> <u>(c) HHS Disparities Action Plan,</u> <u>(d) Reducing Preventable Hospitalizations Among Nursing Facility Residents</u></p>	<ol style="list-style-type: none"><li data-bbox="541 289 1974 321">1. In (d), last sentence, we think one of these words should be stricken: "align coordinate."<li data-bbox="541 354 1974 451">2. UCare supports the idea that the interface of the dual demo with other CMS initiatives should not result in dual eligibles enrolled in other CMS demonstrations needing to disenroll from MSHO, thereby disrupting long standing care coordination arrangements.



**Hennepin County
Human Services and Public Health Department**

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April 19, 2012

Pamela J. Parker
Department of Human Services
Purchasing and Delivery Systems
PO Box 64984
St. Paul, MN 55164
Re: Demonstration to Integrate Care for Dual-Eligibles

Dear Pam:

I am writing with comments from the Human Services and Public Health Department on the DHS proposal for a Demonstration to Integrate Care for Dual-Eligibles as requested in the State Register notice.

Areas of support

- Although Long Term Services and Supports (LTSS) will not be capitated and incorporated with MCOs and the dual demonstration, we support efforts to require collaborative work between LTSS, HCH and ICSPs to improve outcomes for people. It is important that LTSS have the opportunity to work with and learn from HCHs providers and new programs they are implementing for those shared clients that have complex and intensive needs.
- We support your position that the risk and gain sharing corridor arrangement utilized in its SNBC contracts apply to the entire integrated rate setting process for all people with disabilities enrolled under this demonstration.
- We support the DHS position that CMS "grandfather" in existing D-SNP and MCO networks as part of the Medicare/Medicaid Integrated Care Organization (MMICO) transition, that additional HSD tables not be submitted, and that CMS defer to the state for approval and override of CMS network determinations. We agree with the rationale that, as stated in the State Register, "these networks are currently in place and have already been approved by both the state and CMS as meeting CMS and State adequacy requirements".

Recommended changes

- Safeguards should be added in either a memorandum of understanding or in legislation which will require all entities involved to share the risk, cost savings and client data¹ related to this effort. Specifically, we request clear language that will prevent counties from assuming the historical role of the "safety net" for services provided by the county between the clients' involvement with other entities, or when the clients' services are not covered.

¹ Currently it is difficult to acquire data from MCOs on both specific clients as well as aggregate data on the populations we serve.

- We also recommend that cost savings as a result of the demonstration should be shared and targeted to primary prevention efforts – either through the counties or MCOs – for members participating in these programs or in the community.
- Regarding Integrated Care System Partnerships, we recommend:
 1. Clarifying the distinction between ICSPs and MMICOs.
 2. Make the marketing rules surrounding ICSPs and MMICOs less restrictive than those that exist around the current plans offered by MCOs.

If the DHS proposal is selected, we hope that there are future opportunities for the counties to participate in design and implementation discussions. Specifically, as more information becomes available about the viability of the proposed financial model, we hope that DHS will engage stakeholders, such as counties, in the development of outcome measures.

Thank you for the opportunity to comment on the proposal. We support your efforts to build on current state initiatives to improve care and coordination of services for the dual eligible population.

Sincerely,

A handwritten signature in black ink that reads "Todd Monson". The signature is written in a cursive style and is followed by a vertical line.

Todd Monson
Area Director



VIA ELECTRONIC SUBMISSION

April 19, 2012

Deborah Maruska
Minnesota's Dual Demo Project Coordinator
Purchasing and Service Delivery
Minnesota Department of Human Services
PO Box 64984
St. Paul, Minnesota 55164-0984

Re: Draft CMS Design Proposal for Public Comment: Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

The Pharmaceutical Research and Manufacturers of America ("PhRMA") appreciates the opportunity to submit comments regarding Minnesota's draft proposal for Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota.¹ PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports Minnesota's efforts to improve integration of care for persons dually eligible for Medicare and Medicaid with a "continued focus on person-centered individualized care coordination to achieve a seamless beneficiary experience."² We recognize the State's long experience with integrated care for this vulnerable population and support its reliance on Medicare Advantage D-SNPs in creating the demonstration program for elderly duals. Use of these plans, which are also Part D plans, will ensure that the demonstration meets the Guidance provided by CMS that plans should meet the Part D standards and beneficiary protections.

However, in integrating care for the dual eligibles, or any care transition, no matter how carefully planned, will always result in some discontinuities. Indeed, the Minnesota proposal states that "enrollment in a Medicare demonstration including Part D services

¹ Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota (March 22, 2012), (hereinafter "Minnesota's Proposal") available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_167870.

² Minnesota Proposal at 1.

Pharmaceutical Research and Manufacturers of America

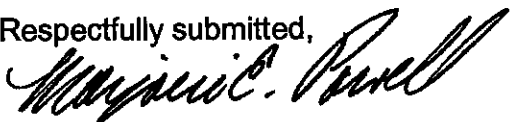
will require MSC+ and most SNBC members to change Part D plans."³ Even if MMICOs will be held responsible for "assuring continuity of current Part D pharmacy benefits for any enrollees with disabilities choosing to enroll,"⁴ we would encourage Minnesota to articulate a set of specific standards that will assure continuity of care for the beneficiaries during the transition. This helps give all concerned – patients, their families, and providers—confidence that their needs are at the center of the plan of care. As the proposal recognizes, changing Part D coverage "can be challenging to beneficiaries."⁵

Additionally, we believe the dual eligibles demonstration in Minnesota and all participating states should be viewed and conducted as a true demonstration. By contrast, the size and scope of Minnesota's demonstration cast it as more of a permanent program change. Minnesota's proposal states, "for the first time CMS has the authority to make successful dual demonstration models permanent, giving Minnesota a chance to apply its expertise in this area to shape a new national policy."⁶ However, the demonstrations are not authorized to become permanent if legislative changes are needed. In keeping with the nature of a demonstration, Minnesota should consider limiting enrollment to a modest portion of the State's eligible population. Minnesota also should require the development of robust data, rigorous monitoring and evaluation of plans (e.g. setting up control groups) prior to enrollment of beneficiaries.

* * * * *

We thank you for your consideration of these comments on the Draft CMS Design Proposal for Public Comment: Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota. We urge Minnesota to revise its proposal in a manner that provides added safeguards to enhance coordinated care and minimize unnecessary disruptions to care for Minnesota's most vulnerable beneficiaries, so that all demonstration enrollees experience the same seamless transition that the proposal anticipates for current MSHO D-SNP members. We look forward to the opportunity to continue working with Minnesota in its development of this demonstration. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

Respectfully submitted,



Marjorie E. Powell

³ Minnesota Proposal at 27

⁴ Minnesota Proposal at 10.

⁵ Minnesota's Proposal at 27.

⁶ Minnesota proposal at 9.

April 19, 2012

Deborah Maruska
DHS – Purchasing and Service Delivery
PO Box 64984
St. Paul, MN 55164-0984.

RE: Draft Proposal for Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

Dear Ms. Maruska:

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to comment of the draft proposal for *Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota*. We look forward to working with the state as this matter moves forward.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. Chain pharmacies fill the majority of Medicare Part D and Medicaid prescriptions, making them a critical access point for healthcare services for dual eligibles.

The goals of the CMS “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative are to improve performance of primary care and care coordination for individuals eligible for both Medicare and Medicaid and to eliminate duplication of services for these beneficiaries, expand access to needed care, and improve the lives of dual eligibles, while lowering costs. Under the program states are eligible to share in the savings their demonstration produces.

NACDS believes the appropriate utilization of pharmacist-provided medication therapy management (MTM) services can play an important role in helping states meet these goals, improve the lives of dual eligible beneficiaries and allow the state to share in the savings achieved. Research has shown that only 50 percent of patients properly adhere to their prescription drug therapy regimens. Poor medication adherence costs the nation approximately \$290 billion annually – 13% of total health care expenditures – and results in avoidable and costly health complications, worsening of disease progression, emergency room visits and hospital stays. This inadequate medication adherence rate is associated with about \$47 billion annually for drug-related hospitalizations, an estimated 40 percent of nursing home admissions.

Reasons for patient non-adherence to a medication regimen are multiple, including costs, regimen complexity and patient beliefs. This is especially true for the dual eligible

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population whose care is fragmented between the Medicare and Medicaid programs. The fragmentation of care can often lead to beneficiary confusion and increase the possibility that a beneficiary may not adhere to his or her medication regimen.

Pharmacists are the most highly trained professionals in medication management. They receive a minimum of six years and in many cases eight years of college, with four years enrolled in a College of Pharmacy where they study medication uses, dosing, side effects, interactions and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in ensuring patients take their medications as prescribed. MTM services provided by community pharmacists improve patient care, enhance communication between providers and patients, improve collaboration among providers, optimize medication use for improved patient outcomes, contribute to medication error prevention and enable patients to be more actively involved in medication self-management. Pharmacist-provided MTM services are one of the many ways of using a pharmacist's clinical skills to improve patient outcomes. Pharmacists already have the training and skills needed to provide MTM services and currently provide many of these services in their day-to-day activities.

In order to be effective in improving outcomes for the dual eligible population through increased medication adherence, MTM services should be provided in a setting that is convenient and comfortable for the beneficiary; this is especially true for beneficiaries transitioning from the inpatient hospital setting or long-term care setting. Because most patients obtain their prescription drugs and services from their local pharmacy, the convenience of pharmacist-provided MTM services is not only logical, but is a cost effective way to increase patient access to MTM services and coordinate the beneficiaries medication.

In the pharmacy setting, MTM includes services such as review of the patient's prescription and over-the counter medications, reconciliation with medications received in the hospital, development of a personal medication record for a beneficiary to share with his/her physicians(s) and a medication-related action plan to achieve specific health goals in cooperation with his/her pharmacist. To perform the most comprehensive assessment of a beneficiary, personal interaction with direct contact between a pharmacist and a beneficiary is optimal. A face-to-face interaction optimizes the pharmacist's ability to observe signs of and visual cues to the beneficiary's health problems. A recent study published in the January 2012 edition of *Health Affairs* demonstrated the key role retail pharmacies play in providing MTM services to beneficiaries with diabetes. The study found that a pharmacy-based intervention program increased beneficiary adherence and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study also suggested that the interventions, including in-person, face-to-face interaction between the retail pharmacist and the beneficiary, contributed to improved behavior with a return on investment of 3 to 1.

As a matter of fact, Minnesota has already had great success in providing MTM services. The Minnesota Medication Therapy Management Care Program was created to provide

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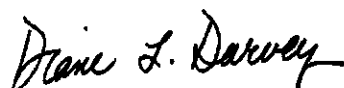
services to low-income residents taking four or more prescription medications and having two or more chronic conditions. In 2006-2007, the program generated a total savings of approximately \$2.11 million, with the state share estimated at \$1.05 million. Approximately 62.2 percent of the total savings were the result of overall decreases in the number of hospitalizations, clinical office visits, emergency room visits and urgent care visits. Total expenditures for all patients enrolled were reduced by as much as 31.5 percent, decreasing the cost per patient from approximately \$11,965 to \$8,197 annually. Minnesota has the opportunity to replicate these successes for dual eligible beneficiaries.

Not only must Minnesota ensure that it maximizes its utilization of MTM services for beneficiaries currently eligible to the Part D MTM program, NACDS suggests that the state consider using this demonstration as an opportunity to expand the use of MTM to include duals eligibles entering Medicare for the first time and those beneficiaries in transitions of care. Doing so would target beneficiaries that often fall through the cracks and would increase their health outcomes and lower overall program costs by providing help early in the process, before lack of coordination and poor medication adherence can become an issue. For newly eligible beneficiaries MTM services would serve a vital role in coordinating care and understanding any prescriptions the beneficiary may have received through Medicaid as well as any over-the-counter drugs the beneficiary may be taking, would ensure that any future prescriptions paid for through the program would be safe, effective and appropriate. Similarly, beneficiaries transitioning from a hospital or a long-term-care setting are vulnerable to miscommunication between different provider types. Pharmacists are in the best position to minimize any chances for miscommunications by acting as the main source for monitoring and managing a beneficiary's prescription medications, both immediately during the transition and continuing on as the beneficiary continues to live in the community.

For these reasons, NACDS encourages the state to maximize the promotion and utilization of MTM services provided by community pharmacists as a means for improving the health benefits in its initiative to integrate care for the dual eligible population. In doing so Minnesota should also consider increasing access to those beneficiaries eligible for Medicare for the first time and beneficiaries transitioning from hospitals and other long-term-care settings.

Thank you again for the opportunity to provide you with this information. We look forward to partnering with you in the future on issues impacting retail pharmacy.

Sincerely,



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