Minnesota Department of **Human Services**

January 31, 2011

Centers for Medicare & Medicaid Services (CMS)
CMS, OAGM, AGG, DSPSCG
Attn: RFP-CMS-2011-0009/Charles Littleton
C2-21-15 Central Building
7500 Seucrity Boulevard
Baltimore, Maryland 21244-1850

Re: Submission of Proposal for State Demonstration to Integrate Care for Dually Eligible Individuals, RPF-CMS-2011-0009

Dear Mr. Littleton:

Enclosed please find Minnesota's response to the request for proposals for state demonstrations to integrate care for dually eligible individuals. This proposal is submitted by the Minnesota Department of Human Services, the government agency charged with administering the state's Medicaid program. Minnesota's experience in providing integrated care for dual eligibles within the current Medicare Advantage Dual Eligible Special Needs Plan platform, the progress in statewide implementation of health care homes, and state legislation paving the way for accountable care organization and total cost of care model reform makes Minnesota an ideal laboratory to focus on the promise of these innovations for dual eligibles. This proposal seeks to take existing primary care and care coordination models to a new level of consistency and performance, advance provider level payment reforms, stabilize the Special Needs Plan platform, develop linked Medicare and Medicaid data bases, and develop sophisticated cross system sub-population performance metrics and risk sharing models for use across all service delivery systems.

Thank you for the opportunity to apply. We look forward to working with the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office to improve care for dual eligibles. Please contact Gretchen Ulbee, of my staff, at 651-431-2192 if you need any additional information.

Sincerely,

Scott Leitz

Scott Leitz
Assistant Commissioner for Health Care

Minnesota Department of Human Services Design Proposal
February 1, 2011
State Demonstrations to Integrate Care for Dually Eligible Individuals, RFP- CMS- 2011-0009

1. BACKGROUND AND OVERVIEW of STATE'S APPROACH TO INTEGRATING CARE

Minnesota's Health Reform Initiatives
Minnesota has a long history of innovation for dual eligibles. Under its widely known integrated programs, Minnesota Senior Health Options (MSHO) for dually eligible seniors, and Special Needs Basic Care (SNBC) for dually eligible adults under age sixty-five, Minnesota holds full risk capitated Medicaid contracts with 13 Medicare Advantage (MA) Dual Eligible Special Needs Plans (DE-SNPs) serving over 43,000 seniors and people with disabilities.

Against this backdrop, Minnesota is in the midst of implementing a complex mix of health delivery, payment and purchasing innovations as part of its overall health reform strategy. These innovations align directly with new goals and opportunities provided through the Patient Protection and Affordable Care Act (PPACA). At the core of the strategy is implementation of an all payer Health Care Home (HCH) program which includes a statewide provider certification process, a common complexity-adjusted per-member per-month (PMPM) payment methodology for care coordination, and provider accountability for a broad range of performance outcomes. CMS approved the addition of care coordination under HCH to Minnesota's state plan in July, making the benefit available under all delivery systems (managed care and fee-for-service.[1] Forty-eight clinics representing over 450 individual primary care clinicians have been certified by the Minnesota Department of Health (MDH). We expect that one in six primary care clinics will be certified by the end of 2011. Efforts are also underway to link HCH with local public health and social services resources to maximize efficiency.

Building on the State's HCH model as a base, Minnesota was approved to participate in the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) which will provide Medicare payment for Medicare beneficiaries including some dual eligibles served under fee-for-service (FFS).[2] In addition, recent state legislation provides broad authority for development of Total Cost of Care (TCC) models such as Accountable Care Organizations (ACOs) or Integrated Care Networks (ICN), and development work has begun.[3] Finally, Minnesota is implementing the PACE program for the first time and intends to issue an RFP this spring. While most seniors are already served under managed care options, PACE provides another integrated care choice and is a natural fit with our other HCH and ACO/TCC initiatives. PACE providers may also choose to be certified as HCH. Through this grant, Minnesota seeks resources to allow more robust implementation of the concepts commonly shared by PACE, MSHO, SNBC and HCH.

Minnesota's experience in providing integrated care for dual eligibles within the current SNP platform, its strides toward statewide implementation of HCH, and state legislation paving the way for ACO/TCC reform makes Minnesota an ideal laboratory to focus on the promise of these innovations for dual eligibles. This proposal seeks to take primary care and care coordination models within the current SNP platform to a new level of consistency and performance by filling in gaps in the implementation of statewide Medicare and Medicaid HCH for dual eligibles. This proposal also seeks to advance provider level payment reforms including integrated Medicare and Medicaid ACO/TCC models to improve integration/coordination for

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[1] Link to Minnesota's HCH State Plan Amendment:
http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_151290.pdf
[2] The MAPCP proposal includes a description of the Minnesota Health Care Home model and analysis of cost savings projections. Link: http://www.health.state.mn.us/healthreform/homes/medicare/index.html
[3] Authorizing legislation for the ACO models may be found at the following links:
https://www.revisor.mn.gov/statutes/?id=256B.0755 and https://www.revisor.mn.gov/statutes/?id=256B.0756
Legislation was also passed for an ACO network pilot in two metro counties which will involve the two largest hospitals serving public programs. See: http://www.health.state.mn.us/healthreform/homes/index.html

dual eligibles enrolled in both FFS and managed care delivery systems. In order to assure that all of these models have an effective impact on both costs and quality, we need to develop linked Medicare and Medicaid data bases; sophisticated cross system sub-population performance metrics; appropriate risk adjustments, and risk sharing models, specific to dual eligibles for use across all service delivery systems. To enable this effort, this proposal also seeks to stabilize payments for the State's current integrated programs, including exploration of shared savings models with CMS for the State's dual eligible SNPs in place of current bid processes.

Proposed Demonstration Goals

- Stabilize current DE-SNP options for continued seamless comprehensive statewide integrated Medicare and Medicaid primary, acute, behavioral and long term care services for dually eligible seniors under Minnesota Senior Health Options (MSHO). Stabilize Special Needs Basic Care (SNBC).DE-SNP options statewide by expanding enrollment statewide and implementing strategies for further integration of physical and behavioral health coverage with FFS long term care services for SNBC members. Improve primary care consistency in these SNP programs through implementation of cross system measurement of the effectiveness of HCH and ACO/TCC care models statewide in both programs. Obtain waivers from certain features of the SNP platform to facilitate these goals.
- Design and implement collaborative mechanisms for education and outreach, and communication, referral and transition protocols and integrated care plan tools between HCH, behavioral health, SNPs and long term care services for people with disabilities served under SNBC SNPs and FFS including a plan for design of pilots for web-based integrated care planning.
- Develop linked Medicare and Medicaid data bases specific to dual populations that can be used across all delivery systems for benchmarking, performance measurement, risk adjustment, and provider payment model development.
- Implement, measure and evaluate the impact of HCH and ACO/TCC primary care delivery models on dual eligibles enrolled in integrated SNP programs by creating and using consistent measures specifically appropriate for dual eligibles across both SNP and FFS payment systems, including measures relating to transitions out of institutional care, care coordination, community integration and social support.
- Develop and provide incentives to increase capacity of provider based HCH/ACO/TCC payment models to improve care for dual eligibles with aligned incentives between Medicare and Medicaid under both FFS and managed care delivery systems by building risk adjusted payment models, methods for attribution of patients, risk sharing corridors appropriate to the provider group size; and outcomes measures appropriate for dually eligible populations.
- Obtain Medicare participation in the ACO/TCC models for dual eligibles served through new state FFS provider contracting initiatives.

Current Delivery Systems for Dual Eligibles

The State has a long standing statewide managed care delivery system for public programs managed by the Minnesota Department of Human Services (DHS). The Prepaid Medical Assistance (PMAP) and Minnesota Care programs serve over 535,000 recipients statewide. Managed care organizations (MCOs) for those programs are also actively engaged in implementing HCH and in developing ACO/TCC models.

As noted above, Minnesota has been at the forefront of integrated care for dual eligibles, creating the first fully integrated Medicare Medicaid dual eligible demonstration in1995. All Medicaid seniors, including dual eligibles, are required to enroll in managed care and may choose between the fully integrated MSHO or Minnesota Senior Care Plus (MSC+) Both MSHO and MSC+ include Medicaid coverage for primary, acute, mental health and long term care (LTC), including HCH and all Elderly Waiver services. MSC+ is not integrated with Medicare, although some members have enrolled in non-integrated Medicare Advantage plans. MSC+ serves about 11,500 dual and non dual seniors statewide, however most have chosen to enroll in MSHO as an alternative. MSHO serves 37,000 senior (65+) dual eligibles statewide through contracts with 8 local nonprofit Medicare Advantage Special Needs Plans (SNPs) who have a history of commitment and experience in providing Medicaid services in Minnesota. .

SNPs provide full encounter data to the State for all services including Medicare Part D. Working closely with the State, SNPs also have developed collaborative approaches to statewide transitions planning, as well as collaborative Performance Improvement Projects (PIPs), care coordination oversight and member materials development. A large proportion of the State's integrated SNPs have achieved 4 Stars under the new CMS rating system. SNPs have long contracted with provider "care systems" paid through various TCC arrangements that include care coordination and shared risk and gain across primary, acute and long term care services. Three of the larger SNPs serve a majority of MSHO enrollees under these models.

People with disabilities age 18-64 are not required to enroll in managed care. However, they may voluntarily enroll in Special Needs Basic Care (SNBC) which provides integrated primary, acute and behavioral health services including HCH benefits, to over 5,000 dual and non dual people with disabilities through 6 MCOs, 5 of which are also integrated Medicare/Medicaid SNPs. SNBC was designed especially for people with disabilities by a large stakeholders group which meets quarterly to advise the State on the managed care programs for people with disabilities. In addition to most State Plan services, SNBC includes all Medicaid mental health services including Mental Health Targeted Case Management. 38% of SNBC enrollees meet state criteria for serious mental illness; therefore SNBC has been a platform for a number of physical and behavioral service integration initiatives. SNBC was offered statewide until 2012, when two SNPs were forced to drop the program due to high premiums generated through the Medicare Advantage bid process. However coverage remains for all but 9 counties. A third pioneering program for people with disabilities, Minnesota Disability Health Options (MnDHO) was also developed and supported by stakeholders but had to close down for 2011 after dropping its SNP in 2010 due to similar bid problems.

About 5,000 mostly dually eligible seniors exempt from managed care enrollment and about 47,000 dual eligibles age 18-64 with disabilities are served through FFS. The state has worked to improve care for dual eligibles with complex disabilities in the FFS system through implementation of a primary care coordination system which is now being provided through the HCH benefit, and we look forward to the opportunities presented by the recent approval of the MAPCP demonstration.

Overview of Minnesota's Dually Eligible Senior and Disability Populations and Benefits
Services for seniors and people with disabilities comprise over 65% of all Medicaid spending. Minnesota serves an average monthly caseload of 106,629 Full Benefit Dual Eligible (FBDE) seniors and people with disabilities. About 50.6% are seniors age 65 and older while 49.4% are people with disabilities age 18-64. Services for dual eligibles comprise about 40.4% of all Medicaid spending. (See Table 1 below.)

Table 1. Minnesota Full Benefit Dually Eligible Medicare and Medicaid Aged and Disabled July 2009-June 2010 Cash Basis Expenditures

Average Monthly Enrollment	Basic Care	HCBS Waivers	Institutional LTC	Total	Average annual cost per person
Age 65+ 53,982	$ 203,991,000	$ 221,462,513	$ 704,410,923	$ 1,129,864,436	$ 20,930
Disabled 18-64 52,646	$ 228,939,277	$ 1,308,354,457	$ 163,642,669	$ 1,700,936,403	$ 32,309
TOTAL 106,629	$ 432,930,277	$ 1,529,816,970	$ 868,053,592	$ 2,830,800,839	$ 26,548

Despite recent cutbacks, Medicaid benefits for dual eligibles remain comprehensive. Minnesota has four main home and community based waivers, three for people with disabilities, and one for seniors. There is currently no waiting list for seniors, though waiver slots for people with disabilities are capped. Medicaid also covers a full range of mental health services and recently added the Health Care Home benefit.

Problem Statement and Policy Rationale

A. Stabilize the SNP Platform to Improve Primary Care in Integrated SNPs through Health Care Homes

HCH implementation throughout Minnesota provides new opportunities to improve the focus of primary care delivery under Minnesota's integrated Medicare/Medicaid SNP programs, including strengthening their current care coordination models to develop closer working relationships with primary care to benefit members. Minnesota's contracted MCOs, including integrated DE-SNPs, must provide payments to certified HCH. While the State is obtaining Medicare payments directly from CMS for HCH for dual eligibles served in FFS under the MAPCP demonstration, that demonstration excludes Medicare beneficiaries enrolled in Medicare Advantage plans including dual eligibles in SNPs. However, the State has gained the cooperation of the dual SNPs and is leveraging their Medicare financial participation in HCH payments through its Medicaid contract requirements.

While the State's model integrated SNP programs have been highly successful in providing consistent care coordination to all enrollees in compliance with the State's extensive contract criteria, there is much variation among primary care clinical models in SNPs. This has sometimes impeded evaluation of care outcomes and has been perceived as a weakness of the program. On the one hand, this variation has allowed experimentation with a variety of approaches to primary care and care coordination, leading to innovative TCC physician directed comprehensive primary, acute and long term care coordination models designed for dual eligibles while also accommodating the flexibility needed to address differences in primary care delivery between rural and metro areas. But for care coordinators operating outside of those integrated TCC systems, communication with clinics and physicians has often been challenging. In addition it has been more difficult to develop such TCC models in rural areas where networks and provider interest may be limited.

Now, HCH provides a consistent platform for improvement of primary care for dual eligibles in both metro and rural areas in the integrated SNP programs. The State wants to use HCH and related TCC models to further the effectiveness and consistency of primary care, including implementation of strategies for further integration between HCH, local public health, and social services. Clear identification of which entity has ownership of each component of care coordination and a single party with oversight of the entire plan is essential, because several parties may participate in care planning.). Also essential is the development of measures appropriate for evaluating the impact and cost effectiveness of HCH models on the care of these dual eligibles enrolled in all delivery systems including the integrated SNP programs.

SNPs have led the way in developing provider based TCC care system models for dual eligibles. Three metro area SNPs serve the majority of their members under these arrangements. Care coordinators operating as part of physician directed TCC systems work for or closely with physicians. In past studies this model of care has been perceived as highly effective. Since a number of SNPs already have adopted payment models that align incentives through appropriate risk and/or gain sharing with providers, DHS has recognized HCH payment arrangements beyond monthly care coordination fees in its managed care contracts for dual eligibles. Contract requirements for alternative models were strengthened for 2011. However the State lacks consistent measures appropriate for evaluating the impact on and cost effectiveness of the care of dual eligibles across these SNP based TCC models. Again, measures developed must be consistent with measures applicable to dual eligibles used in other delivery systems.

Unfortunately, just as these opportunities to bring the promise of integrated Medicare/Medicaid programs to new levels present themselves, the future of the State's integrated SNP programs is at risk. MA benchmarks in MN are lower than most states in which SNPs operate. In the past two years four SNPs in MN have dropped out due to financial issues related to the generation (or potential generation) of premiums through the MA bid process that dual eligibles cannot pay. Some SNBC SNPs in particular have told us they may not get through the bid process for 2012 without premiums Actuaries predict premiums for other SNPs in 2013. Current MA policies around frailty factors and the lack of inclusion of physician Sustainable Growth Rate (SGR) payments in benchmarks continue to threaten the State's pioneering integrated programs. Therefore, the State seeks to stabilize the current SNP platform in Minnesota through waivers or policy changes to address the following issues:

- Access to the HCC Frailty Adjustor based on HOS-M survey of Nursing Home Certifiable members identified through data from the State's MMIS system for MSHO Fully Integrated Dual Eligible (FIDE) SNPs.

- Exemption of integrated DE-SNPs from the MA Part C bid process and allow SNPs to reconcile Part D premiums similar to PACE programs. Replace the bid process with full integration of Medicare and Medicaid benefits similar to PACE with a shared savings model between SNPs, CMS and the State. Use the PACE county rate book (including the rural floor) for payments instead of Medicare Advantage benchmarks for payment.
- Implement improvements in the CMS HCC risk adjustment system for people with complex disabilities by further recognition of the medical complexities involved in serving large numbers of members with severe mental health needs.
- Strengthen policy for continued integration of enrollment, member materials, benefit determinations and grievance and appeals systems.
- Similar to PACE, allow alignment of procurement and contracting timelines between CMS and the State to allow gaps in service areas to be covered more quickly, in particular to expand the SNBC program coverage statewide and to implement other payment changes noted above no later than January 2013 and earlier if possible.
- Streamline and consolidate oversight processes, outcomes measurement and reporting requirements in conjunction with CMS and the SNPs to accommodate measures and additional requirements related to HCH, state long term care and SNPs that are most relevant to dual SNP populations.

B. Implement Integrated Care Planning Strategies for People with Disabilities

While seniors are served almost entirely through managed care in Minnesota, current state policy is to preserve choice between managed care and FFS options for dually eligible people with disabilities and for their long term care services to remain in FFS. However, the State has had in depth experience with integrated Medicare and Medicaid primary, acute and long term care for people with physical and developmental disabilities through MnDHO. Though disability advocates were highly supportive of MnDHO, this program had to close at the end of 2010 due to financial difficulties noted earlier. In addition, advocates helped design and have been highly supportive of our current SNBC program especially as a platform for navigation assistance and behavioral and physical health integration but are worried about its stability and do not support broad inclusion of long term care services under SNBC. Current state policy, the concerns of disability advocates; the complexity of the states' different disability waiver programs; the lack of expert resources for disability LTC services available to managed care plans; and the financial instability of the SNBC program preclude wide scale capitated LTC for people with disabilities at this time.

Therefore the State is looking for ways to bring primary, behavioral health and long term care together through integrated communications, transitions and care planning within both SNBC and FFS through HCH relationships, including, perhaps, financial incentives or risk sharing.

People with disabilities may end up with several care plans, i.e. for county LTC services, for SNPs, for behavioral health and for HCH. To avoid this we need to integrate multiple care planning processes and link care coordination between these service components. SNPs can assist with implementation of outreach and education, standardized communication plans, transition and referral protocols, and shared assessment and care plan summaries between HCH, SNPs, behavioral health and community long term care services for their members. An expectation that one caregiver will have oversight of all care coordination efforts and clear identification of the party with primary responsibility for each component of the care plan is a central tenet of Minnesota's approach. Similar mechanisms should be implemented in FFS, beginning with regional pilots to test protocols, communication models and care planning.

C. Incentives for ACO and TCC Models in Managed Care and FFS

The state wants to provide additional incentives for taking HCH models to the next step by providing carefully designed market aligned incentives and dual specific payment models for providers to serve dual eligibles under all payer ACO/TCC models in FFS as well as in managed care systems. While Minnesota is fortunate to be able to access integrated Medicare and Medicaid coverage under SNPs to include dual eligibles in these payment models in managed care, there currently has been no way to include Medicare in models paid under FFS, severely limiting the ability to include dual eligibles in ACO/TCC models. As part of this proposal, Minnesota requests CMS Medicare participation in projects being developed under existing state legislation authorizing ACO models consistent with those called for in PPACA.

D. Integrated Dual Data Bases and Analytics for Measurement and Risk Adjustment
To tailor implementation of all of these HCH and ACO/TCC models to dual eligibles, to determine their viability, to evaluate their impact, to provide appropriate incentives to support successful best practices, and to provide appropriate feedback to providers on performance, it is essential that DHS invest in improving the availability and analysis of data related to dual eligibles. The State is in great need of resources for the development of linked Medicare and Medicaid data bases, and for appropriate data analysis for development of benchmarks, risk adjusted performance measures, timely data feedback mechanisms for providers, and provider based gain and loss sharing payment models specific to the dual populations and dual subgroups in both managed care and FFS delivery systems. Like many other states under severe budget pressures, it has been difficult to obtain resources to devote to these tasks.

Compounding this problem, dually eligible populations, particularly those with disabilities, comprise a very small percentage of patients served by most primary care practices. While services for dual eligibles comprise a major portion of costs for states and CMS, primary care practices find it difficult to make it a priority to serve and improve care for dual eligibles with severe mental and physical challenges. Although major efforts are underway to develop measurements and benchmarks for HCH and ACO/TCC models serving the broader populations that dominate medical practices, it is unlikely that these measures will be tailored to the needs of these special populations without the special efforts outlined in this proposal. It is also crucial that measures across all of the settings serving dual eligibles including FFS, SNPs, Medicaid MCOs and PACE be consistent. Therefore it is imperative that DHS lead the way in investing in and developing linked Medicare and Medicaid data, measurement systems, risk adjustment and payment model evaluation to assess total costs of care and performance specific to dual eligible populations. We are grateful for this opportunity to obtain funds to make sure our reform efforts can appropriately include and be applicable to dual eligibles.

2. OVERVIEW OF STATE CAPACITY AND INFRASTRUCTURE
Minnesota has a proven track record of implementation of successful health care innovations in its public programs. DHS pioneered the creation of integrated Medicare and Medicaid programs for dual eligibles starting in the early 1990s, under the leadership of Pamela Parker, MPA, Manager of Special Needs Purchasing, Managed Care and Payment Policy (MCPP) Division. Later the program was successfully transitioned statewide under SNP authority and expanded to include people with disabilities. Pamela is also co-leader of the DHS PACE team. These activities are overseen by Karen Peed, Director of MCPP and the State Medicaid Director.

Through Karen's leadership, 2011 managed care contract requirements were enhanced to increase reporting of outcomes for HCH and HCH/TCC alternatives and to add price information on encounter data claims. Karen also spearheaded the implementation of the hospital-based Coordinated Care Delivery Systems to serve the state's General Assistance Medical Care recipients, and is involved in the design and contracting for the new ACO pilots.

The DHS Medical Director, Jeff Schiff, MD has been instrumental in national and state efforts to develop and implement HCH for public programs, and is responsible for the delivery of medical services under the state health care programs, including those for dually eligible people with disabilities served under fee-for-service. In addition, Jeff has led the DHS partnership with its sister agency the Minnesota Department of Health in its successful bid to obtain Medicare participation through the MAPCP demonstration as well as for approval of the SPA in place to provide HCH under Medicaid. He is also involved in the design of the ACO pilots and other TCC models.

DHS will establish an interdivisional team led by Jeff Schiff and Pam Parker to lead the design phase and develop and implement the demonstration proposal. The team will include key staff with experience with integrated programs for dual eligibles, HCH and ACO/TCCs from Jeff and Pam's offices as well as the State's Medicaid Director, Ann Berg the State's Deputy Medicaid Director, Karen Peed, Director of MCPP and representatives from the HCH certification program at MDH. Key staff from the Aging and Disability Divisions, Mental Health and the Performance, Measurement and Quality Improvement Division will also participate on the management team. The team will meet at least monthly to oversee the design phase. Experienced state staff already working with dual eligible initiatives under Pam and Jeff's teams will

provide additional staff support to the project. Project staff will also be hired through this contract, particularly for project coordination, management of contracts and deliverables, development of the integrated care planning process and data analysis functions.

Minnesota also expects to employ contractors for assistance in development of dual databases, risk adjustment, analytic and payment models. DHS will need to conduct procurements for these functions and cannot do so until project funds are secured due to the State's open procurement requirements.

3. DESCRIPTION OF CURRENT ANALYTIC CAPACITY

Currently DHS has access to Medicare and Medicaid integrated encounter claims data including Part D claims for all dual eligibles enrolled in MSHO and SNBC but lacks the resources for analysis of these claims beyond what is needed for rate setting and contract purposes. The lack of analytic resources devoted to utilizing this data has precluded the full utilization of this extensive data and limited evaluation of the State's integrated programs. Starting in July of 2011, encounters will also include Medicaid prices. The state has established a workgroup to develop processes for handling integrated Medicare and Medicare data from SNPs on Medicare services. The state does not currently have authority to obtain prices for Medicare covered services for SNPs, but expects to obtain additional detail on cost data from SNPs through this process.

Minnesota does not have access to linked Medicare data for MSC+ enrollees or for duals with disabilities in fee–for- service and lacks the necessary resources for developing linked data files and analyzing such data. Timely access to this data is essential to the demonstration goals. A key goal of the design phase is to link Medicare and Medicaid claims to produce integrated data base to fill in these gaps and to obtain resources for analyzing the data to develop benchmark measures, risk adjustment of measures, payment models and provider feedback mechanisms. The linked database must include data from the MAPCP in order to reflect all HCH services and Medicare payments for dual eligibles served through fee-for-service.

However, DHS has past experience with linked databases and over the years has had several Data Use Agreements (DUAs) with CMS for an integrated data base for duals that was developed by JEN Associates and utilized until 2002. At that point resources for maintaining the data were lost, and have been unavailable since due to state budget cuts. However, this experience has made us well aware of the intricacies involved in developing a matched Medicare and Medicaid data base for duals and what resources are required to house and maintain the data. Minnesota hopes to obtain this data once again through the Federal Coordinated Health Care Office (FCHCO), contract for resources to link and assist with analysis of the data, and to hire staff with project funds to conduct some of the analyses.

DHS also has extensive experience with data analysis for risk adjusted payment systems for dual eligibles and other populations. DHS uses the ACG model for payment of PMAP plans and for development of tiers for HCH payment structures, the CDPS program for SNBC, a specially designed LTC risk adjustment system for MSHO/MSC+, and has extensive experience in analyzing diagnostic data for fee for service populations.

4. SUMMARY OF STAKEHOLDER ENVIRONMENT

Support for the integrated SNP programs (MSHO and SNBC) among consumers remains strong in Minnesota as evidenced by the low disenrollment rates and high CAHPs and Star ratings for these programs. Seniors have supported the seamlessness of care coordination and access to care across settings under MSHO, which includes all long term care services. However, while disability stakeholders, including mental health advocates, remain extremely supportive of SNBC despite numerous plan closures over the past two years, most are not supportive of including LTC in capitated programs and are adamant about retaining both fee for service and managed care options for dual eligibles with disabilities. Recent closures of several SNP plan options have served to reinforce their concerns. The Disability Managed Care Stakeholders group meets quarterly and was responsible for the design of SNBC and includes virtually all disability advocacy organizations including mental health advocates. It will be critical to engage them in integrated care planning processes between primary care, behavioral services and long term care through HCH and ACO/TCC models under both FFS and managed care.

The State has already had discussions with integrated SNP and MCO contractors on the need to strengthen HCH and ACO/TCC model implementation for dual eligibles enrolled in the integrated SNPs. They have expressed willingness to work with the State to implement the goals of this proposal assuming that some changes to the SNP platform to make it possible for them to participate are part of the demonstration. DHS meets with this group monthly and will continue to involve them in the project.

In addition, DHS will establish a stakeholders group for this demonstration made up of representatives across a range of consumers, community measurement experts, staff involved in other related projects on HCH and ACOs, providers and health plans. Additional working sub-groups around measure development, risk adjustment and payment models and provider feedback mechanisms will be part of this Duals Demonstration Stakeholder group. Consultation with other existing stakeholder groups will also be sought during the design phase of this demonstration including:

- The SNP Clinical Practice Workgroup, which meets quarterly, consisting of SNP Medical Directors, Minnesota Community Measurement (MCM), Institute for Clinical Systems Integration (ICSI), Stratis Health (our QIO) and clinicians and TCC systems involved in SNP programs.
- The Minnesota Board on Aging (in coordination with the DHS Aging Division.)
- The Health Services Medical Advisory Committee (HSAC) a statutorily mandated group of clinicians and providers that advises the DHS Medical Director.
- Medicaid Citizen's Advisory Committee
- DHS/MDH HCH advisory groups including the HCH Learning Collaborative, the HCH Outcomes Advisory Work Group, the Consumer/ Family Council and the MAPCP Advisory Group and HCH providers.
- The ACO Demonstration Stakeholders group
- County Social Service and Mental Health, Public Health Agencies and Tribes.

5. PROJECT TIMELINE

April – June 2011
Pre Proposal Approval • Establish Duals Demo Team and meeting schedule, begin Team meetings • Meet with SNPs to discuss project goals and identify strategies for linking or integrating care coordination and care planning systems with HCH implementation and incentives for TCC models • Assess data sources, and additional storage and system needs • Apply for duals data DUA from FCHCO Month 1 (April) • Begin Monthly CMS Conference Calls • Establish plan with CMS for SNP Waiver design • Draft detailed work and communications plan • Establish alignment links with broader State work groups on HCH and ACO/TCC (MDH, MCM, ACO) • Develop and issue staff PDs and consultant RFPs • Establish Design Demo Stakeholders group (reps from a variety of groups to meet monthly during design phase) • Execute DUA with FCHCO/CMS Month 2 (May) • Hire and orient staff • Begin meetings with SNBC SNPS to develop designs for physical/behavioral health/LTC Integrated Communications/Transitions/Care Planning Tools for people with disabilities • Disability Stakeholders: Input on designs for physical/behavioral health/LTC integrated Communications/Transitions/Care Planning Tools • HSAC and MCO Clinical Practice Workgroup Meetings (briefings and input) • Meet with MDH HCH, MCM and ACO project leaders • Develop process for identifying interested providers for FFS ACO/TCC arrangements

- First Duals Demo Stakeholder group meeting

Month 3 (June)

- Execute consultant contracts
- Obtain CMS Medicare Data/Access to data for contractors
- Provide Medicaid data for linked data base to contractors
- Contractor Deliverable: Work plan for linked Medicare Medicaid duals data

Contractor Deliverable: Data analysis plan for Performance Metrics/Risk Adjustment and Provider Feedback System

July-September 2011

Month 4 (July)

- Begin linked dual data development work
- Contractor Deliverable: Work plan for TCC/ACO (including provider gain/loss sharing) Duals Payment Models
- Meet with interested providers on FFS ACO/TCC models
- Stakeholders Meetings: discussion of potential performance metrics, risk adjustment and provider feedback systems

Month 5 (August)

- Interim proposed 2012 SNP contract requirements development
- Stakeholders Meetings: discussion of TCC/ACO Duals Payment Models
- Determine scope of benefits for FFS ACO/TCC models
- Preliminary System Change Plan due

Month 6 (September)

- Finalize plan for SNP Waivers with CMS
- Issue RFI for SNBC Expansion
- Contractor Deliverable: Dual Data Base with population descriptions/profiles
- Interim Progress Report Due to CMS
- Disability Stakeholders: Recommendations for SNBC physical/behavioral health/LTC Integrated Communications/Transitions/Care Planning Tools

October - December 2011

Month 7 (October)

- Conduct data analysis of dual data base for Performance Metrics/Risk Adjustment and Provider Feedback System
- Stakeholders Meetings: Review dual data base population descriptions
- SNP contract negotiations: Add preliminary requirements to support integrated care coordination planning tools for 2012

Month 8 (November)

- Contractor Deliverable: Performance Metrics /Risk Adjustment and Provider Feedback System
- Contractor Deliverable: ACO/TCC Duals Payment Models
- Finalize 2012 Integrated SNP Contracts
- SNP RFI Responses Due
- Stakeholders Meetings: Review plans for Integrated Transitions and Care Planning Tools

Month 9 (December)

- Staff Deliverable: Integrated Transitions and Care Planning Tools Design and Implementation Plan Due
- Stakeholders Meetings: Review recommendations for Performance Metrics/Risk Adjustment and Data Feedback Models and ACO/TCC Duals Payment Models
- Notice of Intent to CMS for SNBC Expansion

Obtain letters of interest from providers for ACO/TCC in FFS

January-March 2012

Month 10 (January)

- Staff Deliverable: Overall Cross System Evaluation Plan due
- Finalize CMS Waiver Plan including Shared Savings Model
- Finalize Integrated Transitions and Care Planning Tools Design and Implementation Plan
- Finalize Recommendations for Performance Metrics/Risk Adjustment/Data Feedback

- Finalize Recommendations for ACO/TCC Duals Payment Models
- Finalize CMS participation in FFS ACO Payment Models for duals
- Draft Final Report to CMS

Month 11 (February)

- Draft outline of CMS Demo Proposal Due
- Draft CMS Proposal
- Submit Final Report CMS

Month 12 (March)

- Submit Contract Proposal to CMS

Begin Implementation upon CMS approval

- CMS SNP Waivers to Stabilize SNP Platform for Duals in MN
- Expansion of SNBC Statewide
- Cross Systems Measurement Systems and Provider Feedback Systems for Dual Eligibles HCH in SNPs and FFS
- TCC/ACO Payment Models in SNPs and FFS
- Integrated Transitions and Care Planning Tools for People with Disabilities in SNPs and FFS

6. BUDGET AND USE OF FUNDS.

Budget Period April 2011- March 2012			
Technical /Analytic Support Contracts	**Time**	**Rate**	**Total**
Dual Data Base Development			$ 300,000
Performance Metrics/Data Feedback/Risk Adj.			200,000
ACO/TCC Duals Payment Models/Actuarial			178,000
Subtotal Contractors			**$ 678,000**
Staff FTEs			
Project Manager/Policy Coordinator	1.0	90,000	
Policy Development/Stakeholder Facilitator	1.0	70,000	
Data/Analytics Project Manager	.5	50,000	
Data Analyst	1.0	74,000	
Subtotal Staffing			**284,000**
Project Support			
Systems/Data Capacity			25,000
Staff Travel			3,000
Meeting Expenses/Video Conferencing			10,000
Subtotal Project Support			**38,000**
TOTAL			**1,000,000**

SECTION J- LIST OF ATTACHMENTS

J.1 ACCOUNTING CERTIFICATION

NOTE: This information should correspond to the information in the Central contractor registration (CCR) Database

NAME of STATE	Minnesota Department of Human Services
ADDRESS	540 Cedar Street St. Paul, MN 55155-3802
CONTRACTOR POC/ TELEPHONE NUMBER(S)	Jayne Rankin/ 651-431-3432
DUNS (Data Universal Numbering System #)	803894203
TIN (Taxpayer Identification Number)	416007162
CAGE CODE#	3X6T7

SIGNATURE

1/28/2011

For CONTRACTOR Date

Charles E. Johnson

Chief Financial Officer

Minnesota Department of Human Services

SECTION K – REPRESENTATIONS, CERTIFICATIONS, AND OTHER STATEMENTS OF OFFERORS OR QUOTERS

K.1 N/A

K.2 CERTIFICATION OF FILING AND PAYMENT OF FEDERAL TAXES – FAR 352.204 (MAR 2008)

(a) The offeror certifies that, to the best of its knowledge and belief:

1) It has filed all Federal tax returns required during the three years preceding this certification;

2) It has not been convicted of a criminal offense under the Internal Revenue Code of 1986; and

3) It has not been notified of any unpaid Federal tax assessment for which the liability remains unsatisfied, unless the assessment is the subject of an installment agreement or offer in compromise that has been approved by the Internal Revenue Service and is not in default, or the assessment is the subject of a non-frivolous administrative or judicial proceeding.

(b) The signature on the offer is considered to be a certification by the offeror under this provision.