Minnesota’s Dual Demonstration: Managed care model to promote integration of Medicare and Medicaid

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AGENDA

• Managed care background
• Minnesota’s unique need for a demonstration
• Opportunities to better integrate
• Challenges
• Successes
• Improved outcomes for beneficiary experience
Minnesota’s Managed Care and Medicare/Medicaid Integration History

- Medicaid Managed Care since 1985
- In 1995, first approved CMS state Medicare/Medicaid demonstration (MSHO)
- MSHO since 1997
- The MSHO program expanded statewide through contracts with 8 local non-profit FIDE-SNPs in 2005/2006
Overview of Minnesota Senior Health Options (MSHO)

- Combines Medicare (including Part D) and Medicaid services
- Includes Elderly Waiver (MLTSS)
- Includes 180 days of nursing home care
- Enrollment in voluntary instead of mandatory enrollment in Medicaid Managed Care Program (MSC+)
- 70% have chosen to enroll in MSHO
- Approximately 35,000 enrolled
- Operating statewide
- All seven MSC+ plans participate
MSHO Features: Overview

- Integrated member materials, one enrollment form, aligned enrollment dates, one card for all services
- State MLTSS assessment tool integrates Health Risk Assessment (HRA into assessment process
- All members are assigned individual care coordinators. The State sets uniform standards, audit protocols and criteria for care plans, face to face assessment and care coordination
- Flexible care coordination delivery models
MSHO Features: Overview (continued)

- High degree of collaboration among SNPs and State on member materials, PIPs, care coordination, benefit policy, demo decisions, etc. through multiple joint workgroups
- Health plans waive Medicaid co-pays for members
- State level Stakeholders group, each SNP also has local stakeholders group.
- Aligned capitated financing supports innovation and payment reform
Overview of Related Managed Care Programs

- Mandatory medicaid managed care program for seniors: Minnesota Senior Care Plus (MSC+)
  - About 13,000 enrollees, 85% dual
  - Does not integrate with Medicare

- Voluntary program for people with disabilities: Special Needs BasicCare (SNBC)
  - About 49,000 enrolled, 48% of those eligible and 53% of enrollees are dually eligible for Medicare and Medicaid
  - Program covers behavioral and physical health services, not MLTSS
  - Most programs aren’t integrated, history of SNBC SNP’s dropping the program
Integration and Rebalancing

**Enrollment by Setting of Care 1996 and 2014**

<table>
<thead>
<tr>
<th>Setting of Care</th>
<th>1996</th>
<th>2014</th>
<th>Total = 55,611</th>
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<tbody>
<tr>
<td>Community</td>
<td>14,837</td>
<td>20,045</td>
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<tr>
<td>Nursing Facility</td>
<td>30,104</td>
<td>12,968</td>
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<tr>
<td>Elderly Waiver</td>
<td>4,726</td>
<td>22,598</td>
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- 1996: Community (29.9%), Nursing Facility (60.6%), Elderly Waiver (9.5%)
- 2014: Community (36.0%), Nursing Facility (23.3%), Elderly Waiver (40.6%)
The Demonstration’s MOU

- Not an FAD, an administrative alignment demonstration focused on beneficiary experience
- Some of the key objectives include:
  - Develop and test new ways of measuring quality
  - Simplified and unified set of program administration rules and materials
  - Allow CMS and the State to continue to work together integrated within context of Medicare Advantage
  - Enhance quality care, improved service coordination
  - Reduce administrative burdens
  - Align with state provider payment and delivery reforms
Minnesota’s Unique Need for a Dual Demonstration

- D-SNPs designed to serve people dually eligible for Medicare and Medicaid, but state has no clear avenue to communicate with CMS Medicare and provide oversight of CMS’s work with D-SNPs
- The State was looking for improvements in coordination between state and CMS, supported by MedPAC report
- Conflicts in procurement, enrollments, and operations between State and CMS D-SNP policies threaten Minnesota’s integrated programs
- MMCO has cited the MN Demo as a potential precedent for other States seeking improvements in coordination with SNPs
A Few Initiatives Under the Demonstration

- Integrated Model of Care
- Integration and simplification of member materials
- Integration of Medicare and Medicaid claims data
- Unified Quality Metrics
Integration Challenges

- Lack of opportunity for the State to contribute to quality metric development and testing.
- Creating capacity to bring data in house - efficient in the long run, but resource intensive at the beginning of the project.
- Medicare Managed Care model materials were limited and the State could no longer make improvements. Demonstration allowed State to work with CMS on using MMP materials instead.
Successes

- Integrated MOC
- Creating RFP to provide culturally diverse outreach
- CMS is serious about integration among States, and supporting unique needs of D-SNPs with creation of MMCO and ICRC. Regular communication with dedicated MMCO staff.
- The demonstration provides a model for other states to consider when savings can no longer be promised, but want to continue and improve integration
- Promoting person-centeredness across Medicare, Medicaid, MLTSS
Improved Beneficiary Experience

- Improved marketing material language
- Determining improvements for program materials
- Outreach to diverse cultural communities to support culturally-sensitive program components and program awareness
- Care Coordination and Stakeholder Conference
- Integrating the QIP and the PIP
- Integrated Care System Partnerships – targeting challenging areas of care quality and revising delivery model
Minnesota’s Demonstration: Providing opportunities to better integrate

Minnesota has been integrating Medicare and Medicaid for a longer period, has challenges and benefits:

- **Challenges**
  - Unique demonstration, unique initiatives and considerations - additional considerations can cause delays
  - Harder to adjust established system to new developments at federal level
Minnesota’s Demonstration: Providing opportunities to better integrate

- Strengths
  - Have experience and program stability to explore new aspects of integration
  - Long history with managed care allows easier prediction of what works, what doesn’t and what is preferred by stakeholders
Summary

- Minnesota’s unique demonstration allows more appropriate focus for Minnesota’s mature integrated program
  - Unique demonstration = more potential for delays, useful information for other States and CMS
- Increased opportunity to communicate with CMS and collaborate on challenges and integration issues has been key
- Demonstration allowed integration to occur where not previously allowed
- Difficult to estimate the time and resources for unique initiatives
- Avenue to align integration efforts in Minnesota with other State led MLTSS and health care initiatives
Thank you!

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