



Minnesota Department of **Human Services**



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

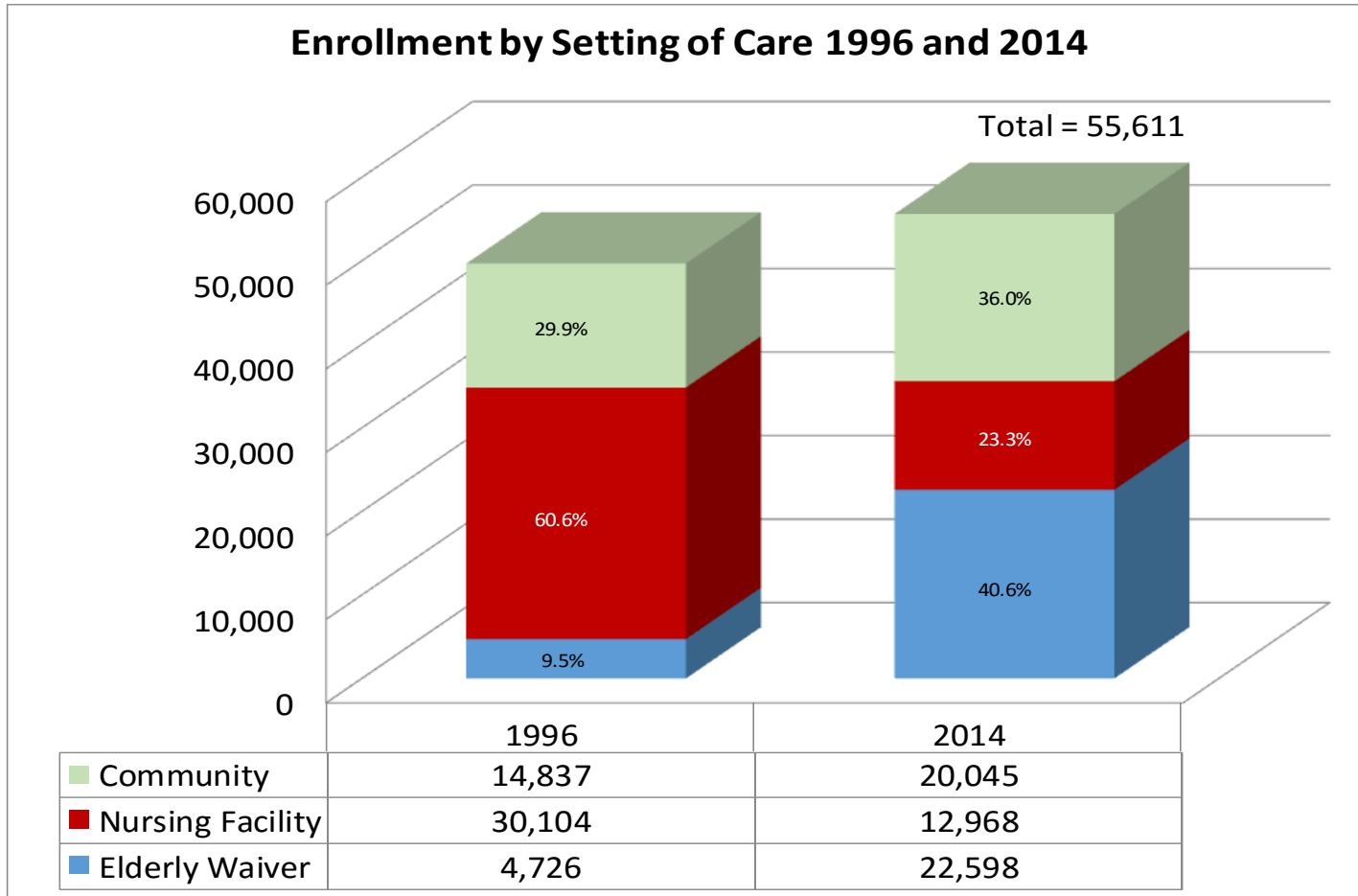


Overview of Related Managed Care Programs

- 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



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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